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**From Aspirations to “Dream-Trap”: Nurse  
Education in Nepal and Nepali Nurse Migration to  
the UK**

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## ABSTRACT

The migration of nurses is stimulating international debate around globalisation, ethics, and the effects on health systems. This thesis examines this phenomenon through nurses trained in Nepal who migrate to the UK. Since 2000, increasing numbers of Nepali nurses have started crossing national borders to participate in the global healthcare market, particularly in the affluent west. By using qualitative multi-sited research and in-depth interviews with key stakeholders in both Nepal and the UK, this thesis explores *why* nurses aspire to migrate, *how* they fulfil these aspirations, and their *experience* of living and working in the UK. The thesis begins by examining the historical development of nurse training in Nepal, particularly from the mid 1950s. This period saw profound socio-political transformations, including in the position of women in Nepali society and in the perception of nursing in Nepal. Previously, many families were very reluctant to send their daughters into nursing. By the late 1990s, middle-class women and their families were increasingly attracted to nursing, both as a vocation and as a means to migrate. The thesis explores the rise of private training colleges to meet the increased demand for nurse training, and the new businesses that have grown up around the profession to facilitate nurse recruitment and migration. Around one thousand nurses have migrated to the UK since 2000, and the second part of the thesis presents their experiences of the migration process and of working and settling in the UK. Nurses have faced complex bureaucratic and professional hurdles, particularly after UK nurse registration and work-permit policies changed in 2006. The thesis also highlights how highly qualified nurses with many years of work experience in Nepal have become increasingly deskilled in UK. Frequently sent to rural nursing-homes by recruiting agencies, they create and join new diasporic support networks. Further, many have left their loved ones behind, and experience homesickness and the pain of family separation. Often, they plan for their husbands and children to join them after several years, and the research explores this and the issues faced by their families, as they relocate and adapt to life in the UK. Finally, the thesis makes some important policy recommendations. For Nepal, these relate to greater regulation of nurse training and the brokering of nurses abroad. In the UK, they relate to increasing the flexibility of registration and visa regulations to

assist in supporting Nepali nurses' work choices, and to value and utilise their professional skills in the UK better.

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This research is dedicated to Nepali nurses in particular, but also to all migrant nurses throughout the world.



### **List of Abbreviations**

|       |  |
|-------|--|
| ANM   | Auxiliary Nurse Midwife  |
| BN    | Bachelor Degree in Nursing                                       |
| BSc.  | Bachelors of Science   |
| CRB   | Criminal Record Bureau   |
| CTEVT | Centre for Technical Training and Vocational training            |
| DH    | Department of Health (England)                                   |
| IEC   | International Educational Consultancies (Nepal)                  |
| IELTS | International English Language Testing System (a British system) |
| INGO  | International Non Governmental Organisation                      |
| IOM   | Institute of Medicine  |
| MN    | Masters in Nursing   |
| MoHP  | Ministry of Health and Population                                |
| NGO   | Non-Governmental Organisation                                    |
| NAN   | Nursing Association of Nepal                                     |
| NNC   | Nepal Nursing Council  |
| NMC   | Nursing and Midwifery Council (UK)                               |
| NVQ   | National Vocational Qualification                                |
| ONP   | Overseas Nurses Programme  |
| PIN   | Professional Identification Number                               |

|     |                               |
|-----|-------------------------------|
| RCN | Royal College of Nursing (UK) |
| RGN | Registered General Nurse      |
| RN  | Registered Nurse              |
| SLC | School Leaving Certificate    |
| TU  | Tribhuwan University          |
| UK  | United Kingdom                |
| WHO | World Health Organisation     |

## **INTRODUCTION**

### **ORIGIN OF RESEARCH IDEA AND RESEARCH DESIGN**

In August 2000, after two years of living back in my home country Nepal, I moved with my family to live in Oxford. Having had a career break of almost two years, I felt that I was ready to go back to nursing. Accordingly, after settling in Oxford, I started to look for a part-time nursing job. Initially, I was quite apprehensive about going back to work for a number of reasons. Principally, I would have to leave our two-year old daughter behind, and this was never going to be easy. Additionally, I felt my professional skills were getting 'rusty' and that I needed to re-orientate and update myself with recent changes within the profession. I joined a nursing agency, the British Nursing Association (BNA), and secured a part-time job. I found going back to work easier than I had expected and, within a few weeks of working as a nurse, I began to notice many interesting changes with the nursing workforce situation in the Oxford area.

Firstly, working with the BNA, I started to meet many overseas trained nurses. At the time, the nursing shortage in hospitals in Oxford and indeed nationally, combined with lengthening hospital waiting lists and the consequent increased recruitment of overseas nurses, was a hot topic. There were many Filipino nurses, for example, who had been recently recruited by Oxford's John Radcliffe NHS Trust. I had the opportunity to work with some of them, along with many others from a wide number of countries, such as Kenya, Australia, South Africa, Zimbabwe, amongst others. The British media were reporting regularly on the changes within the NHS, and covering closely Tony Blair's promise to recruit 20,000 more nurses by 2004 to work in the NHS, in order to reduce waiting lists. As a result, by 2001-02 there were more overseas-trained nurses registered with the Nursing Midwifery Council (NMC) UK than home-trained nurses. I heard many interesting stories and listened to a great deal of gossip, as a part of occupational socialising; some accounts were positive and others negative. I learned particularly that some overseas-trained nurses were exploited in private nursing-homes. One particular encounter with a nurse drew my attention and affected me greatly.

One spring day in 2001, the BNA phoned me and asked me if I could do a shift at a particular nursing-home in Oxford. Stating that this nursing-home always had plenty of work available, they said that, if I wanted, I could work there for as many hours as I liked. I accepted this assignment as I wanted to see what it would be like working in this nursing-home. I went to work there the next morning and, on arrival, met the morning shift staff: some more permanent and others were agency staff, who were there just for a day like myself. We received the night report and started the shift.

There was one other nurse working with me called Mary (her name has been changed). Mary was a trained nurse from Hungary, but she had been working as a carer there. This was because she did not have NMC-UK, registration. Within a few hours of working with Mary, I learned a lot about her situation and the staff recruitment practice of this nursing-home. She was recruited directly from Hungary along with a team of staff from various categories - from carers to kitchen staff, drivers, and cleaners - to work in a number of nursing-homes in Oxfordshire owned by the same person. I was informed by some other staff that every now and again, the owner and the manager of this nursing-home business went to Hungary and recruited nurses and other support staff directly from there. Staff were given a fixed-term contracts usually for one or two years. Accommodation was provided by the management but with a charge. When new batches of staff arrived in Heathrow, the manager would arrange for somebody to pick up them from the airport and take them to their pre-booked accommodation.

Mary and some of the other carers I worked with that morning were, as noted above, part of a bigger group of a wider category of staff recruited to work in this nursing-home. Mary had a two-year contract to work here and, when I met her, she had been there for almost eighteen months. Part of her contract was that she would receive an adaptation course<sup>1</sup> in this nursing home first and then she could register with the NMC-UK.<sup>2</sup> She would be able to thereafter get a staff nurse position there. But time passed and this did not happen, she told me. This was because there was no mentor available to support her with the process. She was disappointed and very unhappy

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<sup>1</sup> This is a short term conversion course for overseas trained nurses under supervision. Upon satisfactory completion of this, the supervisor will recommend full registration with the NMC, so nurses can become fully licensed practitioners in the UK..

<sup>2</sup> The NMC is the professional regulatory body for nurses, midwives and health visitors. Registration is mandatory to work as a professional practitioner. This is further discussed in later chapters.

there. She felt exploited as she was working a 12-hour day for 5 or 6 days a week, on a low wage, but she could not change her job. When I further enquired as to why she could not just leave this place, she told me that her passport had been taken away and was being kept by the management. The informal practice of this management was to keep foreign employees' passports until the end of their work contract, and Mary had six more months still to wait and endure. I felt really strongly that this action was morally wrong but I could not do anything about it. I felt helpless. Working there was a very unpleasant experience, as many staff members were miserable about their working conditions. They were however not supposed to discuss it with any outsiders. They were scared of being deported back to Hungary. I worked there for a week, and felt that a week was enough for me to feel angry and sad. I decided not to accept any further assignments there. However, I remained in touch with some of the staff members for over a year and learned of further horrifying working conditions there.

Next year, I went to Nepal for a short family visit. There I met some friends and former work colleagues. I noticed a major change within the nursing profession there too. I was approached by some senior nurses; some of them wanted to come to the UK, as they had heard that there were many nursing opportunities available in the UK, and others were exploring the business opportunity of linking-up and setting up a network to facilitate nurse migration. Their idea was that they would set up an organisation, in Nepal, to recruit and send nurses to the UK. I, at the UK end, would co-ordinate with them and help find jobs for Nepali nurses. I also learned that other networks like this were already established and fully functioning in Kathmandu, but they were not able to deal with the increasing volume of interested nurse candidates trying to move to the UK.

I began to realise the magnitude of professional and social changes in Nepal. Looking back to just about two and a half decades ago, when I joined nursing in the early 1980s, my grandfather was totally against the idea of me leaving home and moving to Kathmandu, to live in a completely strange place with strangers, without any guardian there. He feared that I might find a man from a different caste and run away with him, or write love letters to a man. There would be no family member to control and safeguard my behaviour. Preserving family honour, caste and culture was desirable behaviour for all, but "a must" for a young unmarried daughter. So, to my

grandfather, the act of my joining nursing training seemed totally inappropriate and presented a risk of ruining his social reputation. This was not just a worry for my grandfather and some of my relatives but for many ordinary families in the 1980s, even though, nursing was and still is the “female only” profession.<sup>3</sup> All student nurses were given “female only” accommodation with a female warden in place 24/7 to safeguard trainee nurses’ behaviour. We had no choice but to stay there during our training for three years. No outside visitors were allowed in the premises and we were not allowed to go out except once a week on Saturdays, only from 10am till 4pm with special permission from the warden. At the time there were only two nursing colleges in the country and training only fifty nurses a year.

This all started to change from the late 1980s. First, there was a major political shift in 1990 that led to the establishment of multiparty democracy in the country. The new democratic government encouraged private sector involvement in education and health and many other development activities. Particularly since then, social perception and attraction towards nursing has changed. The education sector in general as well as nursing education, started to receive more publicity, with a consequent phenomenal increase in demand for more nurse training places. Accommodation rules are much more relaxed, nowadays. Student nurses can choose where to live during their training: in their own home with their family or in a rented flat in town. It is not compulsory for them to be in “female-only” accommodation. From that time young, educated urban girls seemed to get more freedom to move and parents and grandparents became less concerned about their becoming nurses and leaving home. I have noticed nowadays that many parents and grandparents even support and encourage nurses to go abroad for jobs.

Due to the demand for more nursing training places, many new colleges have been set up within the last decade. Indeed many of my friends and colleagues seemed very busy with new job opportunities in these new colleges. After witnessing all these changes, learning of Nepali nurses’ aspirations to migrate to the UK; and hearing about some of the working realities here, the idea of this research began to form. I continued to notice further changes in nursing and in the workforce situation in the

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<sup>3</sup> Except for a brief period, in 1986, when 10% of staff nurse training quotas were allocated for male students. In 1992 nursing reverted to being a female-only profession.

UK healthcare system. Over the next few years, I saw increasing numbers of Nepali nurses coming to the UK. I was particularly struck by the fact that many highly-qualified nurses, with Masters level education and many years of managerial and clinical experience, came to the UK to find they had no corresponding jobs available but were prepared to work at a much lower level than they were used to back home.

This thesis, then, is the result of my research and study into professional nursing in Nepal and Nepali nurses' migration experiences to the UK. The main aim is to explore and understand the experience of Nepali nurses who migrated to the UK. I address two broad questions: how and why do Nepali nurses migrate to the UK and how do they materialise and experience the whole migration process including resettlement here? Finally I make some policy suggestions that I believe are beneficial to migrant nurses, and indeed to the UK healthcare system.

To this end, I followed nurses' professional journeys from Nepal to the UK, not in the sense that I physically travelled with them, but I collected their migration experiences retrospectively and presently. I visited institutions relevant to nurses' professional lives. In order to further understand nurses' professional context in Nepal, I trace the history of nursing there and map-out recent major changes in the nursing profession. The starting point of nurses' journey is their entry into professional training or the conditions under which nurses are trained (in Nepal). The destination for nurses, and an end point of this research, is the UK, where Nepali nurses were living and working at the time of the research field work. Nepali nurses' migration is contextualised as a part of larger global changes in healthcare systems - part of the globalisation in healthcare provision and its relation to international nurse migration. Next, I discuss how I conducted this study and the practical issues I encountered during the course of this thesis.

### **Research method and practical issues**

I chose a qualitative ethnographic style method for this research. Evidently, this research is multi-sited, and fieldwork was done in Nepal and in the UK. In both countries, I have tried to meet with my research informants and visit all relevant institutions in their everyday or "natural settings" (Ritchie & Lewis 2003; Brewer 2000; Gellner & Hirsch 2001; Handwerker 2001). I personally gathered all the

research information, using multiple research techniques including observation, in-depth interviews, and focus group discussions with wider groups of informants (further discussed shortly). As well as these, I have had numerous formal and informal discussions with informants, and reviewed available relevant records and policy documents. Fieldwork was done between Summer 2006 and December 2008, in a total of two years. During this study, I negotiated hurdles and difficulties and exploited positive and favourable conditions as far as possible.

### *In Nepal*

Fieldwork in Nepal was conducted in three stages. The first part of the field work was conducted from August to December 2006. In this time I mapped out the nursing colleges and universities in Nepal, visited some of them, and met with key stakeholders in the nursing sector. I visited the Nursing Association of Nepal (NAN), the Nepal Nursing Council (NNC), and the Centre for Technical Education and Vocational Training (CTEVT), the Ministry of Health and Population (MoHP) of Nepal and numerous nursing colleges. There I met student nurses, qualified nurses, and academics, senior nurses working at policy level, and nurse political activists. I also had some e-mail communication with British Embassy staff in the visa section in Kathmandu. Additionally, I visited some high profile educational consultancies, specialising in brokering nurses abroad. The agencies most 'talked-about' by nurses in Nepal were the UK/US Council, the Versatile Educational Centre, and the Real Dream Educational Consultancy, as they had successfully facilitated Nepali nurses' passage to the UK. I visited them and had an informal discussion with Versatile Educational Centre's office staff and the director of UK /US Council and RN International.

I obtained a list of nursing colleges accredited by NNC from the Council office. Quickly I learned that not all nurse training colleges were on that list. It was initially a confusing process, but, through my personal networks and connections I was able to map out all the existing nurse training colleges.

I visited a total of twenty nursing colleges in Nepal. Four of them had kept a register and recorded if their former graduates had gone abroad or initiated the migration process, but only if had requested a qualification verification letter for a foreign



nursing authority. I reviewed all these records. Most of the records on nurses were from many different states' licensing authorities in the USA, from the NMC-UK, the Nursing Councils of Australia, New Zealand, and Canada. I also met senior academic faculty members and had informal discussions with them. In addition I met a group of BSc. nursing students in their classroom and had group discussions with them about their intention to study nursing.

I went to Nepal for further field work in July / August 2007 and again from October, through November and December 2007, when I visited nursing colleges that I had not visited in my first field work period, and revisited others to update progress and changes within the institutions. I further reviewed available college records of nurses who were in the process of migration, in order to capture changing patterns in terms of numbers involved and the destinations of migrating Nepali nurses.

Additionally, I visited Pokhara, a town in west-central Nepal, where there are three nursing programmes and managed to research one. I went to east Nepal, to the industrial town of Biratnagar and to Dharan. Of the six programmes in this region I visited four.

#### **Map of nursing colleges visited during the research**



Purple circles: Nursing colleges I could not visit; Yellow circles: colleges I visited in Nepal.

A further visit was to the CTEVT where I met three directors and deputy directors from the Exam Division, the Training Accreditation Division, and Research and Information Division.

The final update visit was done between August and December 2008. I re-visited some of the colleges already visited to get further updates, as well as some new colleges not visited before. I was invited to a meeting organised by NAN, and some social events in which I participated were equally valuable and gave me further insight into the issues involved in nurse migration.

Research field work periods had to coincide with my daughter's schooling and my husband's work. I felt that this in fact worked out really well. If I had done all the field work in one stretch, I would not have had the chance to observe some vital changes within the nursing training institutions, and the staff turnover therein. This will be discussed in subsequent chapters.

### *Research in the UK*

In the UK, I met over one hundred Nepali migrant nurses during this study period, using "snowballing" technique (Richie & Lewis 2003), and formally interviewed 21 nurses, as my main informants. Twenty interviews were recorded with permission from the participants. One nurse was happy about the interview but was very shy about being tape-recorded. There were three instances when nurses asked me to turn the recorder off, before sharing personal and sensitive information with me. I spent between four and six hours (sometimes longer) with each nurse I interviewed. I used an open-ended and simple interview guideline to interview these nurses (attached as an appendix), and used some observational methods and informal discussions to gain insight into nurses' professional and social lives in Britain. I also met one nursing-home manager in England who had provided adaptation placements to 78 Nepalis, and one NHS nurse manager in Lothian region who used to be responsible for recruiting and training overseas nurses (before the NMC introduced the Overseas Nurses Programme in 2006).

The purpose of the research interviews was explained to all participants. They were all fully informed and aware that they could withdraw from their participation at any time if they felt uncomfortable or uneasy. Apart from some key public figures, most of the participants I interviewed in the UK are anonymised to protect their identity.

I collected information in Britain from February 2007 to June 2008. Here too, I started contacting nurses through my personal network first, then quickly developed this through “snowballing”. I met nurses’ partners and other family members as well. I visited Oxford city and surrounding villages, Riding Mill in Northumberland, Dundee, Aberdeen, Edinburgh, London, Watford, Hastings and Swansea.

While collecting research data I also used a small notebook to take notes of relevant observations. I kept a diary of field observations, interactions and conversations and professional events in which I participated during the field work (Bell 2005). Later I transferred my notes from the field diary directly onto my laptop. I also wrote a periodic field report with a summary of field data. As well as my interview and observation notes, I used a digital recorder to record interviews as and when possible. I recorded a total of twenty three in-depth interviews: twenty with Nepali nurses in the UK, one with a Programme Chief in a private nursing college in Nepal, one with the President of the NAN and one UK-returned nurse in Kathmandu. Interviews were conducted in a mixture of both Nepali and English. More than half of the conversations were in English, as many informants felt comfortable using English words and often whole sentences in English when in the UK. In Nepal, too, many English words are adopted and widely used by qualified nurses and some senior managers were fluent in English. I later, however transcribed and translated the Nepali recordings into English.

#### *Insider / Outsider context of this research*

Traditionally, in ethnographic research, researchers from “outside” would come to study people in their “natural” settings. However, it is increasingly common to study one’s own world and in different organisational settings (Gellner & Hirsch 2001). In this research, I, as a Nepali nurse, currently working and living in Britain, studied Nepali nurses’ migration to the UK. I see myself as a “participant insider” (Mosse 2005). As Mosse argues, “the social processes of an organisation are better understood from within” (2005:11). Being an insider has raised a number of issues, not least the position it puts me in relation to my research participants. I share the experiences of my research participants: the overall experience of being trained in Nepal and becoming an overseas / migrant nurse in British healthcare settings, and this has undoubtedly been a huge asset. I felt privileged that the nurses I met were

happy to talk to me, and I had easy access to them. I also had good access to nursing colleges and other relevant institutions in Nepal, because of friends and colleagues from my previous jobs, who now occupy senior positions in various organisations. This “old friends’ network” has certainly facilitated access to inside knowledge of the organisations I have researched.

I have been working in the UK healthcare system since 1994, and I have a good understanding of professional nursing registration regulations and processes and, most importantly, recent changes within the healthcare system in the UK. Additionally, since 2005, I have been a member of the Royal College of Nurses (RCN), and of the Overseas Nurses Network Group, Edinburgh branch. This gave me the additional privilege of having access to Overseas Nurses around the region.<sup>4</sup>

Generally, ethnographers spend a long time learning the language and culture of their study population (Gellner & Hirsch 2001). My main advantage in doing this ethnography is I speak, read and write Nepali and English fluently, and this has been invaluable. Language and cultural difficulties were minimal, in comparison to what they would have been, if I had been an outsider conducting this study in Nepal. For example, a PhD colleague of mine who is not a nurse but is conducting very similar research on Malawian nurses’ migration experience to Britain, told me that she had real difficulty in finding enough Malawian nurses who were willing to be interviewed and share their migration experiences with her. She felt this was partly because Malawian nurses were very sceptical about her as an outside researcher, and partly because Malawian health workers have been receiving constant media interest in the UK and globally. This was not the case for me, and I feel that was due to my insider position.

However, the whole process has not been totally smooth nor without some difficulties. Nepal has been going through major political crises since the start of the Maoist War in 1996, and remains unsettled at the time of writing this thesis. Since the start of the Maoist revolution, the country has had two states of emergency declared by the former king, and numerous changes of government. I found researching, at this

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<sup>4</sup> This network group was quite active during 2005-07, advocating issues related to overseas trained nurses. There have been some changes with the leadership within the RCN, ON network group in Edinburgh; since 2008 it does not appear to have been so active.

turbulent time in Nepal, all very slow and frustrating. There had been a government change in the summer of 2006, just after the country was declared a republic. I had just arrived in Nepal to do my research field work. Soon after the change of government and declaration of the republic, many key positions within the nursing sector, filled by ministry level nomination, became vacant as the Health Minister was removed from his position with the change of the entire parliament. With this the President, Vice-President and all the NNC board members were removed from their positions. When I visited the NNC in August 2006, there had been no NNC board member for almost four months, except the Registrar (whose contract was terminated with the others, but who was appointed again very quickly for urgent work only). There were only a few administrative staff, as their posts were not affected by the changes. The Registrar was mostly occupied with professional registration and administration-related work, but all professional regulation and strengthening work was on hold. This affected my work too.

In addition, there was a long-term strike by CTEVT students, which involved many nursing colleges. The CTEVT office was closed, and in fact the dispute in the office led to a general strike by CTEVT staff as well. The council chairman was also removed with the old government, and an interim appointment of a chairman was disapproved of by the staff union, so his office was locked up and staff were all on strike, which lasted for months. This affected my visits to various key institutions.

There have also been frequent, unplanned street protests, blockades, and demonstrations by students and the youth forces of various political parties, as well as other organisations (see Chapter 2 for a brief discussion of the current political situation). Although I did not personally feel especially unsafe during my first fieldwork period in Nepal, the frequent interruptions meant I had to take any opportunities available while gathering research information as and when possible. In addition, in Nepal it was almost impossible to plan and arrange times to meet people, and I always had to be extremely flexible, and ready all the time. This was because of the political situation as well as a particular working culture there.

In the UK, although difficulties with timings were fairly minor, they did exist, and I had to adjust to them and always remain flexible, which caused some difficulty with child-care arrangements. I had to travel long distances to meet nurses who worked

long days and shifts with unsocial hours. Many nurses I met did not have much free time and I had to fit around their working hours. Although the majority of nurses were very willing to be interviewed and were accommodating, it has been difficult to use their only day off in a week for this research. For example, nurses I interviewed in Hastings worked five or six nights a week, with just one or two nights off every week. After finishing night shift they sleep during the day, so getting time with some of them had been a challenge. I was in Hastings twice for my field work (the first time for two days and the second time for four days), and all the time I was there, some nurses I had intended to see were doing night shifts and working longer days (twelve hour shifts), and I was not able to meet them. They were genuinely very busy and tired.

### *Emotional and ethical challenges*

Quite often I have been in emotionally uncomfortable situations. I felt that I was seen as a contact point for aspirant nurses; an *afno-manchhe* (translation: of one's own people) and this has raised some expectations, quite understandably perhaps. *Afno-manchhe* networks are vital in Nepali society and usually work quite well too. While I was doing my fieldwork in Nepal, I was approached by nurses who desperately wanted to come to the UK, but I have never been in the position to facilitate their migration. I was asked for advice and ways to achieve their migration aspirations, but again I was not in a position to advise them. I tried to explain the working regulations in the UK, but that was not what they were looking for. I regularly felt useless in terms of their needs and unable to help them. Having seen overseas nurses' working situation in the UK, I would have liked to advise to them that they should not come, but, at the same time, I could see how desperate they were, and did not want to discourage their international aspirations either. I felt that the whole migration process might mean years of being on an emotional rollercoaster (chapters 6 and 7 will explore this further).

Some Nepali nurses, already here in the UK, have also contacted me to help them find adaptation training placements and jobs, as their visas were about to expire and, if they failed to find a place soon, they would need to go back home, but I could not be of any help to them either. In the UK, there were genuinely not enough training

placements available for overseas nurses. I felt useless again being unable to help them in difficult and stressful times.

Another factor was that the nature of nursing work undertaken might have caused some nurses embarrassment. Some nurses I met in the UK were very experienced and had held senior and permanent government positions in Nepal, but in the UK, they were working as night nurses in the least desired aspects of nursing, such as care of the elderly and in mental institutions, or doing work far below their technical skills and clinical experience. These were sensitive issues that would perhaps have been easier for an “outsider” researcher to discuss and explore more openly. Finally some nurses were on student visas, and were unsure as to whether their visas would allow them to engage in full-time work. Because of the sensitive nature of visa situations, some appeared reluctant to meet with me and discuss their experience in detail.

When it comes to publication and dissemination of the research findings, particularly in Nepal, there is a chance that I will be seen as a “whistleblower” and some participants may feel a sense of betrayal. This research highlights some brutal truths about Nepali nurses’ situation in the UK. I am aware that not all the nurses want to share their negative stories with others in Nepal; and, indeed, not all proud parents would want to hear any negative stories about their daughters in the UK, as nurse migration is seen as a family success in Nepal.

In addition, the majority of managers of nursing training institutions in Nepal have affiliation with major political parties. Social networks are very important in Nepal, and nursing society is still relatively small and nurses are easily identifiable and closely networked. I will not be able to hide my identity. I cannot deny or ignore the fact that my father is a local politician and a member of the Nepal Communist Party, the United Marxist Leninists. Indeed, this has facilitated some openings and closed others, and an outside researcher would have had a quite different experience. I believe that coming from a high caste Brahmin family is less relevant in this regard, as my informants are professionals from the new middle-class society (Liechty 2003) and caste is not as important an issue for my research as local politics.

### *Analytic and validation process*

Data analysis started in the early stages of the research fieldwork and continued until the end. Findings presented in this research are the result of long-term engagement and interaction with my research participants in Nepal and in the UK during the process of data collection and interpretation - a process commonly described as 'immersion' by ethnographers. This iterative immersion results in the research findings being constantly cross-checked. Thus to achieve valid data I used multiple data gathering techniques including observation, attending nurses' meetings and gatherings, formal and informal discussion, interviews, focus groups (when feasible and appropriate), review of records, and news and media representation of relevant issues. In addition to this, being an "insider" in this research means that misinterpretation of cultural meanings and language has been minimised.

I am also aware of the fact that being an insider may also lead to bias. In order to minimise this I did not interview those nurses who are long-term friends and past-colleagues of mine, and I kept my interview samples diverse as already explained. This means that recruitment was not just dependent on my own personal networks, but reflected the broader diversity of nurses.

I organised research data in chronological order following various stages of nurses' migration processes and experiences, which was guided by my research interview guidelines (please see appendix 1). I read and re-read the interview records and field notes, and repeatedly listened to the interviews to discern themes and issues that emerged in the data.

None the less, although ethnographic research generates highly valid data, there is an ongoing debate whether ethnographic research findings are transferable to a wider context. Brewer suggests "...empirical generalisation to wider population are feasible" (2000:77). This also has been suggested by Shenton (2004), Hammersley (1990) and Guba and Lincoln (1985). Furthermore, although this research focuses specifically on nurse migration from Nepal to the UK, the findings are relevant to the wider international nurse migration context.



### *University level ethical approval*

According to the ethical guidelines of University of Edinburgh's College of Humanities and Social Science, this research falls into level one. This was because no vulnerable patients (or people) were involved and interviews and observations were carried out in nurses' social settings, not in clinical areas and were conducted when nurses were off duty. Informants were contacted by telephone first, and a suitable time for them was arranged. They chose their own free time and I travelled to their accommodation.

### **Chapter outline**

In *Chapter One*, I review international human migration history and changing scenario and debates on health workers' migration within the context of globalisation. Globalisation in information and technology, economy and, ultimately in health, plays a key role in international nurse migration. Global interconnectedness and interdependency can not be untangled in the 21<sup>st</sup> century world, and the global movement of nurses is only a part of global human movement. After exploring global migration trends, I focus on the UK as the nurse-receiving country and Nepal as the source country. Both countries have long histories of labour immigration and emigration, including that of health workers. I briefly trace this history up to the present day.

*Chapter Two* is mainly about Nepal and women in contemporary Nepali society. A brief introduction to Nepal is the first focus, highlighting how Nepal became a modern nation state. I explore a brief historical development of public education system. Within this, I examine education for women in the past and presently. Women need to be educated to be eligible for nurse training. The discussion turns to focus more closely on gender politics in Nepal. There has been a phenomenal social change recently, and education has come to be perceived as a tool for wider social change. The core issue in this chapter is how women's position in Nepali society has changed since the 1990s. The migration of Nepali women to foreign countries to work as maids or nannies has been seen as a great opportunity for unskilled women, but nursing opportunities abroad for professional women have been seen as the most desirable and a "passport to a foreign job" is seen as by far the best option for women.

Not only are nurses seen as better positioned for international jobs, but many young educated and successful men now look for nurse-brides. This is now a common knowledge in Nepali society. Young Nepali nurses are not just becoming more mobile, but are increasingly becoming “economic agents”, as well as facilitators of international migration.

*Chapter Three* looks at professional nursing education and the healthcare system in Nepal. Discussion in this chapter starts with a history of nursing and continues by looking at the present situation of professional nursing. There has been a phenomenal change in social perceptions of nursing and a rapid growth in Nepal’s training capacity since the 1990s. The private sector has been involved in meeting the increased demand for training places. As a result, the private sector is growing and the state has not been able to control and regulate this growth in the education sector. I look at the major stakeholders in professional nursing. Setting up a nursing college has been a profitable business and I discuss the political economy of this. As a result of this nurse training can be unregulated and private market-led and no proper joint-planning exists between training institutions and employers. I question the quality of nursing training in the private sector, particularly in a resource-constrained environment that has implications for training. The reality is that more nurses are trained every year and more nurses are leaving Nepal for foreign jobs. They can open up opportunities for a family move abroad. Nurses are seen to be in the unique position of making an international move possible.

Next, *Chapter Four* is about migration decision-making and preparations for migration. Here, discussion starts with how the nurses I interviewed made the decision to migrate and prepared to move to the UK. Nurses talked mainly about what influenced them to make this decision (instead of what their own motivations were). Factors that influence Nepali nurses to migrate are presented here: possible better living standards and future opportunities for nurses themselves and their families. How nurses hear about international opportunities and the increasing global movement of Nepali nurses are further foci. A detailed discussion ensues on how International Educational Consultancies and migration brokers facilitate nurses’ moves. The preparation of false documents (such as bank statements, official letters from education authorities in Britain, and letters with accommodation details) to

satisfy UK visa officers in Nepal is revealed. These documents usually accompany visa applications.

Because of visa and work permit related regulations and bureaucratic hurdles, the steps of getting the qualification, visa and work permit and then a nursing license, all become mixed up: there is no logical progression. Nurses regularly end up taking short cut routes, guided by their friends and colleagues and other informal social networks. Nurses take the route which seems the most likely one for obtaining any kind of entry visa. Some choose to apply for National Vocational Qualification (NVQ) training or other higher education courses. Many therefore come to the UK as higher education students, NVQ or ONP students. Some come with work permits and some as dependant family members. Nurses who have gone to the USA, have gone sometimes as BSc. nursing students, a small number having completed the NECLEX exam. Many Nepali nurses have moved to Australia and New Zealand as BSc. nursing students, even though some of them have studied to this level in Nepal. These most common but very complex routes are examined in this chapter.

From *Chapter Five* this thesis moves on to look at Nepali nurses in Britain, starting with their arrival: where they first go; their initial experiences of settling in and the role of nurses' support networks in Britain. How Nepal trained nurses fit into the British healthcare system is discussed, as there are different regulations for nurses who are trained within the EU countries. Nursing jobs in the UK are firstly for home-trained nurses then EU-trained nurses, after this for those outside the EU. There is no mechanism providing job guarantees for Nepali nurses, and I present case studies to illustrate how difficult it has been for some Nepali nurses to get jobs in the UK. I argue that Nepali nurses are perhaps more vulnerable to exploitation in the private sector, as the door to the NHS is closed for them because the Department of Health's "Code of Practice for International Recruitment of Healthcare Professionals" (DH 2004) in England, put Nepal on the list of banned countries, from which recruitment of health workers was considered unethical. As Nepal is neither a Commonwealth country nor in the EU, Nepali nurses are given the worst 'deal' in the UK job market. For some nurses I interviewed, overcoming the hurdles of gaining a nursing licence (an NMC-PIN), finding a job and securing a work permit has seemed like a never-ending chain of difficulties.

*Chapter Six* examines Nepali nurses and their working lives in Britain: their expectations and the reality. I explore their working relationship with colleagues, managers and patients. Nepali nurses have been disappointed with the working conditions and types of work they have found in the UK. Almost all of them had experienced downward professional mobility initially. Many were highly-trained and had many years of management experience, some with very specialist technical skills, yet have ended up doing very basic care work. Their dreams and expectations of working in a medically and technologically advanced system have totally failed. Their qualifications and experiences have been misplaced in the UK working environment, so they increasingly feel deskilled.

In *Chapter Seven*, I explore the consequences of nurse migration for social and family life and settling as migrant families in Britain. There are numerous hidden costs during the early period of migration, such as the pain of family separation and the hurdles that beset family reunion. Even after reunion, various issues emerge. Nurses' husbands are not used to being socially and economically dependent on their wives in Nepal, but must adjust to their changing social status and live as dependant family members in the UK. To add insult to the injury, many of them have had no choice but to accept unskilled jobs in the UK after giving up highly respectable jobs in Nepal. Some of the nurses' husbands I met had given up well-respected executive positions in Nepal, and were working in the UK in Tesco, Co-op and other supermarkets, in domestic cleaning jobs, or in healthcare assistant jobs. For them migration brings only downward social mobility, frustration, disappointment and demoralisation (Charsley 2008). Despite all this, they still hope their situation will change one day; that they will get better jobs and better social status. Many Nepali Diaspora support organisations have emerged in Britain recently, but those Nepalis who live in rural areas have not benefited greatly, and many are moving around Britain regularly in search of better social support and job opportunities. However, they are not ready to go back to Nepal yet, for a number of reasons including *beijet*, the loss of face and failed aspirations.

Finally *Chapter Eight* concludes the thesis presenting *key findings and recommendations for policy*. In it, I summarise international migration from Nepal and its impact on professional nursing in Nepal: particularly nursing education and

service provision within Nepal. There is a serious shortage of experienced academic faculty members as well as senior nurse managers in Nepal. International nurse migration has undermined nursing education in Nepal because the nurse training curriculum has been revamped in line with the credentials demanded by western countries. Care of the elderly and mental health nursing modules have been added to the revised curriculum to meet this. The number of nurse training colleges has increased, but human and physical resources are very scarce. New types of nurses have been trained, but jobs are not created to employ new graduates.

International nurse migration also has a major impact in Britain. Ethical issues have been raised and to deal with this the “*Code of Practice for the International Recruitment of Healthcare Professionals*” by the Department of Health in England (DH 1999, 2001 & 2004) was developed. But this code had unintended negative consequences for overseas trained nurses by forcing nurses to seek work in the private sector. This guideline has created numerous loopholes in overseas nurse recruitment practice. This combined with tougher NMC registration regulation and tighter border controls dealing with work permits for overseas trained health workers, has only created and fostered space for brokers to operate in a semi-legal market. As a consequence, the majority of vulnerable Nepali migrant nurses are forced into private sector nursing-home, long-term care settings, working in the least desired aspect of nursing, and this has created a different professional class within the nursing profession (Smith & Mackintosh 2007). After summarising the key findings, I make some key policy recommendations regarding migration management and in both Nepal and the UK.

## **CHAPTER ONE**

### **INTERNATIONAL HUMAN MIGRATION: CHANGING SCENARIO AND DEBATES ON HEALTH PROFESSIONALS' MIGRATION WITHIN THE CONTEXT OF GLOBALISATION**

Human mobility and migration have been studied by scholars from various disciplines for many years but social scientists, geographers, economists and historians have increasingly focused on this issue since the 1960s (Castle 2000; Massey *et al.* 2006; Moses 2006; Connell 2008). Various reasons for migration, changes of patterns and directions have been discussed. Most recently, international human migration has been seen as an aspect of the wider process of globalisation. In this chapter I aim to capture this changing global migration phenomenon and review frequently discussed explanations, debates and issues in relation to globalisation and international nurse migration.

#### **A. International Migration Patterns and Theories**

Although there is a great deal of literature available on migration (Castle 2000; Moses 2006; Messina & Lahav 2006; Connell 2008), scholars often cite Massey *et al.*'s (2006) work on global migration theories and patterns. Their work has been the most widely used and influential in the recent migration debates.

Having studied human migration very comprehensively, Massey *et al.* (2006) summarise global migration patterns and classify various periods in modern history. They consider 1500-1800 as the 'mercantile period' when global migration was dominated by European migrants. This pattern was facilitated by the process of colonisation and economic growth. In this period, Europeans migrated mainly to America, Africa, Asia and Oceania as agrarian settlers, with a small number of administrators and artisans, entrepreneurs and convicts. Mainly they went in search of more land (from labour-rich, land-poor countries to land-rich labour-poor countries). After 1800, during the 'industrial period' (1800-1925), Europe remained the main source for migration but there was a shift in destination countries. The vast majority of people went to five main destinations: Argentina, Australia, New Zealand, Canada

and the USA. In this period migration occurred as a result of an imbalance between labour supply and demand. The sending nations had more supply of labour than their demand while the receiving countries needed more labour for industrial growth (Massey *et al.* 2006).

The First World War halted large scale migration, and the authors describe this as a 'period of limited migration', but the Second World War created a large number of refugees and displaced people, who migrated internationally for refuge and safety.

'The post-industrial period' of migration, mainly from the 1960s, manifests itself in very different ways. The old pattern and direction changed considerably, and migration started occurring from wider sources and moving in many new directions and destinations. In this period, migration from Asia, Africa and Latin America increased dramatically. The number of destination countries also grew significantly. As a result, western European countries as well as traditional destination countries started receiving new migrants from a wider number of sources. European migrants then made up only a small fraction of the global flow of migrants. In the 1980s, new migration patterns emerged in Asia and the newly industrialising countries such as Korea, Singapore, Malaysia, Hong Kong, Taiwan, became migrant-receiving countries (Massey *et al.* 2006; Lan 2006; Castle 2000). In brief, migration patterns have changed direction through recent history and present day migration has become more complex and multifaceted, with more people migrating from increasing numbers of source countries.

Various factors and forces cause these changes in migration patterns and directions. Modern day international migration emanates from demographic changes in the capital-rich and labour-poor countries (unrelated now to availability of land unlike in the past). Industrialised and, most recently, industrialising countries face a shortage of labour, both skilled and unskilled. Many developed nations face low birth rates, an increasingly ageing population and a consequent decline in the productive age population. As the number of elderly people rises, consistent economic growth is vital for social security and services, as well as the resources to look after and care for them. These countries also need more labour to maintain and stimulate economic growth. At a time when industrialised and industrialising countries are going through a declining population phase, population growth in some developing countries still

remains high. Labour supply in developing countries remains abundant and many nations do not have the capacity to employ their own citizens, creating a surplus of labour. The need for labour in industrialised and industrialising countries is thus met by this surplus labour from developing countries (Messina & Lahav 2006; Castle 2000).

A further important factor influencing human migration is the increasing sophistication of modern electronic communication technology (Steger 2003; Giddens 1999; Appadurai 1996). Now, people living in one corner of the globe can have almost instant access to news and information from the other corners. The world can seem small. Spatial distances have become less important. Cheap travel and transport systems have also had lubricating effects on human mobility. This has been a dramatic change from only a couple of decades ago.

By the New Millennium, international migration had expanded even further with more source and destination countries involved. To add further to this complexity, new types of migrants have emerged in the international migration field. Mainly from the 1980s, there are increasing numbers of women involved in international migration, a process known as the “feminisation of migration” (Zimmerman *et al.* 2006; Ehrenreich & Russell-Hochschild 2002; Castle 2000). Traditionally men would be the leaders of migration and smaller numbers of women and children accompanied them. Now women constitute almost half of the total migration numbers, and they do not just accompany their male partners but are themselves active agents of migration (Kingma 2006; Lan 2006; Ehrenreich & Russell-Hochschild 2002; Castle 2000). The feminisation of migration is an important issue for this research which I further discuss shortly.

As a result of growing academic and policy research interest in migration mainly from the 1960s, various theories have been developed to explain changing migration patterns and motivations for migration (Messina & Lahav 2006; Massey *et al.* 2006; Castle 2000).

Massey *et al.* (2006) summarise some of the most prominent migration theories, as follows: Neoclassical Economic Theory probably the best known and oldest theory and this focuses mainly on international labour migration for economic reasons.



Within this, neoclassical economic macro-theory explains that international migration is influenced primarily by geographical differences in supply and demand for labour and differences in wage rates (Massey *et al.* 2006: 18-19). It assumes that after a period of human mobility the labour supply and wages, in both sending as well as receiving countries, become balanced and the migration flow decreases. Neoclassical economic micro-theory makes similar assumptions around an individual's decision and choice to migrate and is based on wages and cost benefit calculations. Recently, however, neoclassical economic theories have been challenged by a new assumption that migration decisions are not totally based on individual choices but are sometimes more communal, with people acting collectively (Massey *et al.* 2006:19).

The New Economics of migration is a theory that challenges neoclassical economic theories and argues that migration decisions are made by families or households and sometimes by communities, in which people act collectively to maximise the benefits and minimise the risk of market failure, by diversifying income by sending family members to different geographical locations. This is again based on labour markets and people moving for economic reasons (Massey *et al.* 2006: 21-28).

Historical-structural Theory, or World Systems Theory, was developed in the 1950s; Historical-structural theorists argue that because political power is unequally distributed across nations, the expansion of global capitalism acted to perpetuate inequalities (Massey *et al.* 2006: 34-35). Capital-rich countries are at the centre in global political power and poor countries are at the periphery. Poor countries are trapped by their disadvantaged position within an unequal geopolitical structure, which perpetuates their poverty. This theory argues that international migration is a natural consequence of capitalist market formation and penetration of the global economy into peripheral regions (Massey *et al.* 2006: 34-41). Present-day economic globalisation and multinational companies, and their business expansion and penetration into developing countries, can be explained by this theory.

Finally, Segmented Labour Theory makes similar claims as the Historical-structural Theory. This argues that developed countries have a structurally in-built demand for immigrant labour, so people from developing countries move to meet this demand.

Alongside these major theories are other frequently discussed factors that perpetuate international migration. Social Capital Theory argues that migrants develop their own support network which facilitates further migration. Once the migration process starts, migration support institutions then develop. As we shall see, the emergence of Nepali Diaspora networks in the UK, mainly from the new millennium, and the growth of the international educational consultancies business in relation to international nurse migration in contemporary Nepal, is a good example of this. This will be further highlighted in chapters Four, Five and Six.

Cumulative Causation Theory argues that causation for migration is cumulative: over time international migration tends to sustain itself (Massey *et al.* 2006: 45-50). Massey *et al.* describe eight ways in which migration is affected cumulatively: expansion of networks, distribution of income and land, organisation of farm production then creating a migration culture, and distribution of human capital and social labelling. Eventually certain types of jobs are labelled as ‘migrants’ jobs’. They are not considered suitable for native workers (2006: 48; Castle 2000).

In relation to all kinds of migration and, in particular, to international health workers’ migration, ‘pull and push’ factors are most commonly discussed. This assumes that there are factors such as lack of jobs, poor working and living conditions, lack of professional development opportunities, that ‘push’ migrants away from source countries, and there are ‘pull’ factors such as better jobs and professional opportunities, better living conditions and safety, in destination countries that attract migrants (Kingma 2006; Buchan 2003). These are usually discussed in fairly straightforward ways and mainly in economic terms.

However, there is a general agreement amongst migration scholars that any one theory discussed above is not enough to explain the complex 21<sup>st</sup> century migration phenomenon. The above theories were developed between the 1950s and 1970s. With the new millennium, new demographic shifts and new communication technologies have developed, and the migration patterns have changed. Massey *et al.* (2006), Messina & Lahav (2006) and Castle (2000) suggest that there is a need now for an appropriate examination of new migration patterns and for new theories to explain the phenomenon. It is more important now to understand new demographic and new

migration trends than to contextualise migration as a result of demographic disparities and ‘pull and push, factors.

To this end, Massey *et al.* (2006) propose a new ‘integrated theory of international migration’. In this they suggest that new migration patterns and motivation for migration can be understood in an integrated way, by considering more than one theory, taking relevant aspects of traditional and classical theories that can help us understand and explain the new patterns better. This appears much more relevant to understanding and explaining the changing dynamic of 21<sup>st</sup> century international labour as well as professional migration. This new theoretical approach seems very relevant to this research and useful to explain many aspects of nurse migration from Nepal to the UK.

#### *Main limitations of classical theories of international migration*

There are some weaknesses in these above theories. First and foremost, these theories are mainly based on labour migration. The neoclassical economic theories of migration, both macro and macro, explain the main motivation for migration being based on wage differences. Historical-structural Theory claims that the reason for migration is the structural differences, in political and economic power, in sending and receiving countries and so on. The complex dynamics of modern-day international migration of diverse types of skilled and professional migrants, and, most recently, female migration, cannot be fully explained by any one theory. For example, in this research I have found that earning better wages is one of the many reasons for Nepali nurses to come to the UK. For the majority of these nurses their migration motivations seem to be for better living standards for themselves and their families, combined with professional development opportunities. They are making a commitment for their children’s and families’ future, and ultimately migration to the UK is seen as a sign and symbol of success in their lives. Many nurses were influenced by their friends and families to migrate. Thus, they have diverse motivations and influencing factors for migration, and Nepali nurses’ intentions seem to be a permanent move or long-term settlement plans in the west. Their move is not just for themselves but with their families; for education opportunities and career progress. This is not a temporary move to minimise economic risk as neoclassical economic theory might suggest.

Changing social dynamics is another area that is not explained by old theories. In the context of Nepal, nurse migration to affluent industrialised countries is a manifestation of broader social changes, particularly recent changes in women's position in society (this is discussed in detail in Chapter two), in addition to being part of the global "feminisation of migration".

Pull-push factors are also believed to perpetuate migration. As the world is getting increasingly interdependent these pull and push factors are not so distinctive. But rather, as Castle (2000) argues, migration is a sign of global interconnectedness and interdependency. Now most migration processes are facilitated and supported by electronic media. The majority of professional skilled migrants (except refugees and asylum seekers) are active agents in the migration process: they are not pulled or pushed by various factors such as lack of job opportunities and are available elsewhere. Migrants are usually the best and brightest in the society (Moore 2006), and they interact actively in this interconnected world by using electronic communication technology (Appadurai 1996).

One of the most important factors that determines modern-day international migration is immigration and emigration regulations in both the source and destination countries. This is a very important political issue and, aside from political scientists, has not been fully acknowledged by migration scholars from other disciplines, including economists and social scientists (Zolberg 2006). There are various barriers, such as immigration policy and regulation to control or manage migration, that are created in many destination countries. Migration flows and patterns are sensitive to border control policy in a destination country. For example from early 2000 till 2006, the UK and USA were major migration destinations for Nepali higher education students and nurses, with Australia third in the list of most preferred countries. But in 2008 Australia became the most preferred destination. This was because the UK and US visa policies changed, and visas were very hard to access, whereas Australia had a relatively relaxed visa policy for Nepali students and nurses. These kinds of constantly changing immigration regulations make migration complex.

Recently, human mobility of skilled professionals as well as labour has been contextualised and discussed as an 'old' global phenomenon but one that has escalated rapidly in the last two to three decades because of advancement in

communication technology and cheap transportation and instant availability of information globally. As with many other aspects, the impact of globalisation in healthcare services is very evident (Tschudin & Davis 2008; Connell 2008; Kingma 2006; Buse *et al.* 2005). I now review how globalisation is discussed and examine what effect globalisation has on healthcare resources and services.

## **B. Globalisation**

Many globalisation scholars argue that globalisation is not new. However, as discussed, what is new is the recent advance in communication technology which has facilitated quicker and wider access to information and communication.

Transportation capacity has also increased globally (Moses 2006; Massey *et al.* 2006; Castle 2000; Giddens 1990). After a lengthy discussion of the term globalisation, Steger develops a working definition:

Globalisation refers to a multidimensional set of social processes, that create, multiply, stretch and intensify worldwide social interdependencies and exchanges while at the same time fostering in people a growing awareness of deepening connections between the local and distance (Steger 2003: 13).

In addition, Giddens (1990: 64) defines globalisation:

...as the intensifications of worldwide social relations which links distance localities in such a way that local happenings are shaped by events occurring many miles away and vice versa.

So, clearly the present form of globalisation has contracted time and space. Messages can be communicated quickly, and local events swiftly become global events. Today we are increasingly interdependent. Economic globalisation is a prime example. The global economic slowdown in 2008-09 demonstrates this. No country in the world remains totally independent from global economic and social processes. Similarly, globalisation in media and technology facilitates an instant flow of information and ideas globally. There is immediate access to global resources for those who are part of these processes. Changes in the health sector in one part of the world are communicated to other parts, and are increasingly and inevitably interdependent as well.

### *Globalisation in health*

Globalisation in health therefore is another example of global interdependency and interconnectedness today. Local disease scares can no longer be contained locally, but become seen as global threats the next day. Disease-causing organisms have no barriers, they cross national borders quickly. SARS, Multi Drug Resistant (MDR) TB, and Swine Flu (H1N1 Virus) are examples of this. Healthcare products produced in one corner of the world, are used somewhere else, usually thousands of miles away. Not only do health professionals have global opportunities, but health services in some countries are planned increasingly for global consumers. Medical tourism in Thailand and Cuba; telemedicine facilities in private hospitals in Kathmandu; increasing numbers of multinational companies providing private health services such as eye care and care of the elderly services in Britain (Pollock 2005), are just a few examples of how globally interdependent we are, and of the globalisation in health in the 21<sup>st</sup> century.

Globalisation has many other interlinking facets. Economic, cultural, media and technological globalisation all directly affect healthcare systems, locally and globally, and have no national boundaries. Money is invested globally, and trade agreements are made at global, as well as increasingly at regional levels. Some of these trade agreements on goods and services facilitate regional movements of people: for example, freedom to move and work within the countries in the European Union (EU) and the Caribbean Communities (CARICOM), is made possible by regional trade agreements (Kingma 2006). Health worker migration is part of the whole process of global economic expansion and globalisation in health. China and India currently are trying to produce thousands of surplus nurses for international supply (Khadria 2007; Matsuno 2008). China, India and the Philippines have entered into a bilateral agreement with the British government in the international recruitment of health workers in Britain (Buchan *et al.* 2009). Japan has made agreements with Malaysia and recruited nurses from there to fill nursing vacancies (Matsuno 2008; Connell 2008). Nurses are not only moving from south to north globally, but there new regional patterns are emerging too.

### *Global movement of health workers*

As highlighted above, the international movement of health workers is not new. Filipino nurses have been migrating and working in America for more than a century, Britain has been receiving health workers from its former colonies since the establishment of the National Health Service (NHS) in 1948, after the end of the Second World War (Choy 2003; Mejia 1978). Health services in many Commonwealth countries were built during colonial periods as part of the colonial administration. Healthcare services in the Gulf countries have been thriving on foreign professionals (Kingma 2006, Percot 2006). Irish nurses have been working in Britain, North America, Australia and New Zealand, in EU countries and many other parts of the world since the nineteenth century (Yeates 2008).

As a result of global interconnectedness and interdependence, increasing numbers of healthcare professionals move in this global market place, shifting for personal and professional development opportunities. As large numbers of skilled professionals migrate to wealthier countries, this has been perceived as a problematic and increasingly political issue. As argued by Historical-structural theorists (Massey *et al.* 2006; Castle 2000) this further widens the economic gap between rich 'developed' countries in the north and poor 'developing' countries in the south. Although there are local variations, the migration of health workers recently has been increasingly a one-way flow, mostly from the poor countries in the south to affluent countries in the north. As a result, the gap in health service provision between rich and poor countries and within regions is increasing (WHO 2006). This became a global concern as early as the late 1940s (Buchan & Sochalski 2004) and for the first time in the 1970s, the WHO conducted research to see the world-wide picture of the source and destination countries of migrating health workers. Records on physician and nurse migration for 137 countries were analysed. At that time, however, only a few countries were involved. The Philippines, the UK and Australia were source countries for nurse migration, and the USA, Canada and the UK were the only few destination (host) countries (Mejia 1978). However, this pattern has changed significantly since the 1990s.

There has been an escalating growth in health workers' migration, not only in terms of the number of migrants but in the number of source countries (Connell *et al.* 2007;

Focus Migration 2007; Kingma 2006; Ross *et al.* 2005; WHO, ICN & RCN 2003). International migration of health workers from resource-poor countries in the south has had a negative impact on many developing countries in Africa and Asia, where the health needs are greater and resources are already depleted. This becomes a major challenge, for example, in delivering services to control HIV/AIDS and to address the Millennium Development Goals (MDGs). If we take Nepal's case as an example, the Nick Simon Institute (NSI 2006) reports that while over 50% of district hospitals have no physician in post, over 50% of new medical graduates head overseas.

Technology and health services are improving globally, but at the same time the gap in healthcare service provision between developed countries and developing countries is widening. This, in part, is because of the maldistribution of human resources for health, including nurses. A World Health Organisation report (2006) presents a comprehensive assessment on the global disease burden and the health resource situation. This shows a dire picture of maldistribution of human resources for health and the global disease burden. In the report, the US has 10% of the global burden of diseases, but uses 50% of global health expenditure while the African region has 24% of the disease burden and less than 1% of global health expenditure (WHO 2006).

Since the 1990s, developed countries have also been recruiting nurses, and other categories of health workers, from developing countries to fill their vacancies. This practice of international recruitment of health workers by developed countries was deemed 'unethical' and some developed countries, such as the UK, have tried to address this issue. In 2006, the WHO declared a global crisis in human resources for health. This health worker migration pattern has created a care vacuum in source countries, and has been described as a 'brain drain'.

Emanating from Historical-structural Theory, "brain drain" is described as "the selective migration of talented and educated people from poor to wealthy nations". The idea evolved from the world system theory, later known as dependency theory. The theorists argue that the migration of talented and educated individuals to the rich countries undermines the prospects for development in poor countries by depriving them of essential human capital. Developing nations covered the cost of feeding, clothing, educating and maintaining the emigrants until they reached productive age (Castle 2000; Massey *et al.* 2006). The brain drain actually constituted a "subsidy" of



wealthy nations by poor and “the burden of care in rich countries is now shouldered by women from the poor countries” (Hirschfeld 2008: 19). This is widely exemplified within the context of nurse migration from resource poor countries in Asia and Africa to wealthy countries in the west (Augustine 2005; Duffin & Paris 2005; Baird 2005; Focus Migration 2007; Hirschfeld 2008).

A counter argument to brain drain is the individual right to mobility. Nurses and health professionals have their individual rights to migrate and look for better work and life opportunities. If someone can find better working conditions, career development opportunities and higher living standards for their family, then it is an individual decision. Yet, the right to health for everyone is an important issue linked to health workers’ rights to look for better opportunities. Given the situation of scarce human resources, if people leave their workplaces for better opportunities elsewhere, a crucial question of patients’ safety arises (WHO 2006; Aiken *et al.* 2002). For countries with fragile healthcare systems and inadequate resources, this can have serious consequences for the delivery of essential healthcare. Patients’ safety has to be compromised. This is an ethical dilemma: the individual right to migrate versus, at a global level, the issue of distributive justice (Bertram 2008; Kingma 2006; Bueno de Mesquita & Gordon 2005).

Evidently, the global shortage of nurses (and health workers in general) is a complex phenomenon. I found no standard definition and measurement to determine the degree of nurse shortage in a country. It is not about the sheer number of nurses trained globally to provide healthcare. There has been a severe maldistribution of healthcare workers nationally and globally. Further to this, globally there are large numbers of trained nurses not actively practising nursing (Kingma 2006). Many qualified nurses are not prepared to work within available terms and conditions in both developed and developing countries. Nurses from developing countries are looking for better opportunities in affluent countries, while nurses in these countries look for better opportunities in the wider healthcare sector. In addition, new roles are emerging for nurses in the developed world: nurse managers, nurse consultants, specialist nurses and NHS 24 nurses in Britain. Consequently the need for more nurses in the front line of clinical nursing care is increasing. This is a separate issue, but the main concern is the maldistribution of the available global nursing workforce. The nurse population

ratio in some developing countries is seriously worrying in comparison to that in developed countries. For example, the USA has 773 nurses to 100,000 population but Uganda has only 6 per 100,000, and yet both countries report nursing shortages (Kingma 2006). Similarly, the UK has 6.5 nurses for 1,000 people or 650 for 100,000 people (Buchan 2002) whereas Nepal has 1 nurse for 4987 people (MoHP Nepal 2009), but the UK nursing shortage is far more widely advertised and discussed globally than that of Nepal.

One of the main reasons for the nursing shortage in developed western countries seems to be the increasing demand for more nurses, combined with a stagnating supply and slow growth to meet the need (Connell *et al* 2007; Kingma 2006; Buchan & Sochalski 2004; Buchan 2002). The nursing shortage in developing countries is said to be caused by migration of nurses to developed world, and the impact of HIV/AIDS on the nursing workload in some sub-Saharan African countries (Thupayagale-Tshweneagae 2007; ICN 2005; Duffin & Parish 2005). In one way or another, both developed and developing countries report that they need more nurses. Kingma (2006) highlights that to address these needs there is an urgent need for thousands more nurses globally. Managing this situation is becoming an urgent and major global challenge.

The nursing shortage is a relative phenomenon, determined by the demand for nursing services and existing resources available to meet this demand. Nursing service demand has been very sensitive to a nation's economy and nursing vacancies fluctuate accordingly. For example, looking at the health workforce situation in Britain in the early 1990s during the Conservative government, when the British economy was not performing well, there were large cuts in the NHS staffing levels. However, in the late 90s, when the economy started to recover and boom, this nursing shortage became a major political issue in the UK. In the early years, under the Labour government in the late 90s, more political promises were made, offering wider and better health services. Given the government's need for more nurses to deliver the promises, nursing shortages consequently received more political attention. More money went into the health services and, as they expanded, more nurses were recruited nationally and internationally (Buchan 2002). But, within a few years, after 2005, when some NHS trusts started experiencing budget deficits again, they started axing hospital beds

and nursing posts. If one just looks at the past fifteen years from the mid 1990s, nursing shortages have been a regular political as well as an economic issue in the UK.

Kingma (2006) claimed that there would be a need for 80,000 qualified nurses in the UK by 2008, if much needed services were to be offered to people. Instead, there has been a nursing vacancy freeze and even a reduction in the number of nursing positions since 2006-07. A BBC documentary on the 24<sup>th</sup> of March 2009 on 'Dispatches', entitled "Confessions of a Nurse", highlighted that there was still a critical shortage of nurses brought again to widely acknowledged issue of the nursing workforce being overstretched in many health services in Britain. The programme also highlighted England's urgent need of 4000 additional midwives. Dean (2009) has estimated this number should be 5000. However, it takes years to train and prepare such workforces and money needs to be invested in this process.

Nursing shortages, thus, do not remain static, but the number of vacancies fluctuates according to government policy and available budgets allocated for health services and nursing posts. An ongoing issue for the last few years in the UK, a recent broadcast on BBC Radio Four and BBC News channel online (3<sup>rd</sup> September 2009), warned that, in order to deal with the NHS budget deficit, the British government has to reduce the NHS workforce by 10% by 2014, to save 20bn (BBC News 2009a). Strategies such as further vacancy freezes and the early retirement of health workers have been recommended by management consultants, but the Labour government at the time rejected this advice. As such the maintenance of the health workforce, including nursing, is determined by the country's economy and political commitment.

The nursing shortage in developed countries and nurse migration from developing countries is also seen as a gender issue, and this is my next focus.

### *Global nursing shortage: a gender issue*

Feminist scholars argue that 'care work', both paid and unpaid, is socially sanctioned work for women, both traditionally and also in modern times. Nursing is a caring profession and has always been included in this care work category, as the major aspect of nursing involves looking after and caring for the ill, frail, elderly and

disabled people in society (Zimmerman *et al.* 2006; Kingma 2006; Spitzer, *et al* 2006; ICN 2005). It has been a female-dominated profession globally and is still a 'female-only' profession in Nepal.

With socio-political changes after World War Two, women in many developed countries obtained better-paid as well as wider job opportunities in society. As western women gain broader career choices, the attraction towards domestic work and care work, including nursing, has declined generally. This has created a care vacuum in the western countries, particularly at the most basic level of looking after young children and the elderly. From the 1970s, as Ehrenreich & Russell-Hochschild (2002) argue, increasing numbers of women from developing countries were hired to take these domestic and care work jobs and fill this care vacuum. They do come to look after other people's children, the sick and elderly, whilst leaving their own young children, sick and elderly behind. This type of female migration from developing countries to provide care to people in the affluent north has been described as "care drain" (Zimmerman *et al.* 2006; Ehrenreich & Russell-Hochschild 2002). This care drain has of course created a need for a "care chain" to support those who are left behind (Sassen 2006; Lan 2006).

Nursing and care work is physically and emotionally demanding, involves unsocial working hours and is generally poorly paid. Kingma (2006) highlights that the profession is dominated by females, and is paid less than male-dominated or mixed-gender professions. Because of the nature of the profession - as female-dominated and care work - nursing has been neglected and remains a low-paid profession globally. While the attraction towards nursing and care-work in developed countries is declining, the need for it is increasing because of demographic changes, an increasing number of elderly people, as well as rising healthcare expectations and needs (Cangiano *et al.* 2009). There is an urgent need for more nurses and care workers globally. Rather than improving working terms and conditions locally and nationally, and making nursing an attractive profession, developed countries have been recruiting nurses from resource-poor countries. Nurses and carers have been used as a cheap workforce to fill 'hard-to-fill' care-work posts. Developed countries have been criticised for 'commoditising' nursing in this manner, and not investing in their own preparations for this urgently needed workforce. Rather, they use cheap labour from

economically disadvantaged countries, making care-work into a commodity that can be bought and sold in the contemporary global care market (Kingma 2006; Zimmerman *et al.* 2006; Lan 2006; Herdman 2004). Care is easily available nowadays, for those who can afford to pay. This challenges the fundamental principle of healthcare as a right of all individuals, not only for those who can buy it. Critics view this trend as picking staff off-the-shelves: employing healthcare professionals becomes like supermarket shopping (Smith & Mackintosh 2007).

Although migration researchers and scholars have found no evidence of such, there remain some perceptions around migrants being a threat to local jobs and excessive consumers of the state welfare system (Moses 2006; Castle 2000). Migrants are in fact generally vulnerable and subject to exploitation. Migrant nurses and care workers are commonly seen as economic migrants, and female migrants are doubly vulnerable and more exploited than their male counterparts (Shelly 2007; Zimmerman, *et al.* 2006; Ehrenreich & Russell-Hochschild 2002). Mary, whom I introduced at the beginning of this thesis, demonstrated this exploitation as a European migrant nurse in Oxford. Many migrant nurses in Britain feel similarly exploited and discriminated against at work (Larsen 2007; Allan & Larsen 2003). They are separated from their families and kin, an enormous social cost, to provide care to people in developed countries. Despite all this, international migration opportunity for nurses is still seen as ‘the golden door’ for many Filipino nurses and nurses from developing countries (Baird 2005; Choy 2003). I turn next to migration, and its supporting institutions, in this thriving international business.

### *The thriving global migration business*

There are many layers of commercial opportunities created by contemporary global migration: from education in the home country in order to become ‘migration-able’, through to facilitating individuals arriving in destination countries. To start with, in the context of Nepal, many parents from the middle-classes send their children to private schools in bigger urban centres in Nepal, or India, or further abroad to give their children the best, usually an English-medium, education. As Liechty (2003: 213) suggests:

English proficiency is simultaneously the key to a better future, an index of social capital and a part of the purchase price for a ticket out of Nepal.

The demand for good English-medium education is high. In order to meet the high demands for private English teaching, there has been a recent rapid expansion of privately-run language schools. This seems like a highly profitable business venture. In tandem with this, there has also been a rapid increase in the number of educational consultancies in Kathmandu. The migration process is associated with increased international travel business. Airlines have also increased the numbers of international flights, particularly to the Gulf, and most recently, banking services have also increased significantly. Similarly, a mere decade ago, Kathmandu was connected by only a few international flights a week to a small number of destinations, but by 2009 there are many international flights every day, and a big boom in the airline industry is very evident. On travelling into and from Kathmandu to international destinations, it can be noted that, on the majority of international flights, migrant labourers are carried to the Middle East, Malaysia, Japan, and South Korea (Brusle 2010). Some flights, for example to Seoul with Korean Air, were started in 2007 mainly to facilitate international migration.<sup>5</sup> Until the late 1990s, there were only half a dozen state-run banks in Nepal, but now there are many private banks on almost every main street in Kathmandu, and all are involved in international money transfers (Shakya 2009). Thousands of billboards on street corners in down-town Kathmandu advertise money transfer with the Western Union.

International nurse migration has contributed a great deal too to this global economy (Kingma 2006). Choy (2003) reports that the air transport business grew rapidly in the Philippines when Filipino nurses started to migrate to the USA in the 60s and 70s. Big annual turnovers globally are linked directly to nurse migration and related facilitation businesses such as English language tests and nurse licensing examinations. Almost every country in the world has been affected by the global migration economy and this phenomenon is far too powerful to ignore (Kingma 2006). Nursing migration is here to stay and to grow, and nurse migration from Nepal to the UK is only a small part of a much wider global migration phenomenon.

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<sup>5</sup> To look at the annual economic turnover of these 'side' businesses is beyond the scope of this research.

### **C. Migration in the British Context:**

The history of Britain is full of tales of migration. People have moved around internally and internationally. The Irish Famine forced people to leave for North America and Britain. The Clearances in the Scottish Highlands and Islands displaced large populations, and many moved to North America. In Wales too many people migrated to Slough for jobs (Hayter 2000). After the end of the Second World War many European countries invited 'guest workers' to reconstruct their nations and rebuild their economies (Giddens 2001; Castle 2000). Britain invited workers from her past colonies to fill the labour shortage, and rebuild the war-torn country. In 1945, Britain set up the European Voluntary Workers Scheme, very similar to the 'guest workers' scheme in Europe. As a result, over 90,000 people were recruited from Refugee camps and from Italy (Castle 2000). With this influx also came large numbers of people from South Asia and from the Caribbean (Giddens 2001; Hayter 2000; Castle 2000). In a way, the modern Britain we see today is a country of migrants and immigrants. The health service and many other infrastructures have been established with the help of migrant labour. Many services today, such as the National Health Service and, more recently, domestic cleaning industries and farming, are heavily reliant on migrant workers (Shelly 2007).

#### *Health workers' migration and healthcare system in Britain*

Literature on health workers' migration to Britain suggests that, right from its establishment, the NHS has had some degree of reliance on overseas health workers and at many levels, from nurses and medical staff to domestic and support staff. There has been a long tradition of overseas health workers working in Britain. Even long before the establishment of the NHS (in 1948), Mary Seacole came from Jamaica to help the team of British nurses care for and treat British troops engaged in the Crimean War (1854-56). After the establishment of the NHS, the urgent need to reconstruct the war-torn country and establish the whole new healthcare service in Britain generated a need for more people to work in the new NHS. A recruitment drive was funded by the government to attract qualified nurses and nursing students. This was aimed mainly at Commonwealth countries (Duffin 2008, Philogene 2008; Winkelmann- Gleed 2006; Mejia 1978). The migration trend continued for almost two decades. In 1962, the Commonwealth Immigration Act was introduced by the

Conservative government, in order to control migration flow into Britain. Although the total number of new immigrants declined, dependant family members of migrants could still come to join them in Britain. After the introduction of the Immigration Act in 1971, official entry declined sharply (Freeman 2006; Giddens 2001). Winkelmann-Gleed (2006) suggests that the number of migrating health workers became almost negligible in the 1980s.

The declining inflow of overseas health workers to Britain was not just because of the immigration policy changes, but was also because of a global economic slowdown from the mid 1970s. This became very evident after the rise in oil prices in 1973, which affected many countries globally (Buchan 2000). This economic slowdown pushed many countries into budget deficit. Healthcare systems in many countries, particularly in developing countries were badly hit. To adjust to this changing economic climate, countries adapted and implemented Structural Adjustment Programmes (SAP), designed and prescribed by the International Monetary Fund (IMF) and the World Bank. The 1980s has been significant for the global redesigning and restructuring of health policies, alongside other public services, including the NHS in Britain.

Slow global economic growth affected Britain too, forcing the government to consider many changes in public funding. The Treasury was under immense pressure to reduce public spending and the reduction in NHS funding was just a part of wider public service reform. The main focus of this reform was ‘cost containment’ or getting value for money. Under the NHS reform plan, the new idea of an ‘Internal Market’ was introduced with the aim of using money more effectively. With the introduction of a market mechanism and of consumers’ choice, and the idea of an internal market, cost minimisation seemed the only way forward (Buchan 2000). The private sector was also being mobilised by the government. Pollock (2005) argues that the original principles of the NHS, of comprehensive and universal service were then challenged by the new business model healthcare system. Consequently, the total NHS workforce in clinical areas, mainly those who were involved in direct patient care (including nurses and midwives) was significantly reduced. By 1995, the total nursing and



midwife workforce had come down to 343, 380 from 397, 030 in 1985, a total reduction of 13% or over 53,000 nursing and midwife jobs in Britain (Buchan 2000).<sup>6</sup>

Some of these policy changes by the Conservative government relating to the restructuring of the NHS in the 1980s, were very unpopular amongst NHS staff, including nurses. When the Labour government came to power in 1997, claiming that it inherited a deteriorating NHS, it promised to make positive changes and put more money into the NHS to improve the situation. Hospital waiting-lists became high on political agendas and nursing staff shortages in hospitals became headline news. The Labour government promised to deal with these issues quickly. This needed an injection of extra cash. Fortunately, a sudden economic boom in Britain helped the government to find this extra money to deal with waiting lists and staff shortages. The Labour government promised to employ 20,000 more nurses by 2004.

In order to fulfil the promises and deal with the waiting lists, the NHS needed more nurses and doctors quickly. New ideas of performance and target setting were introduced to encourage local NHS trusts to reduce hospital waiting-lists and recruit more staff quickly and effectively. An easier option for some NHS trusts in the UK was to use expensive agency staff and even consider international recruitment as a 'quick-fix' remedy.

Once again, after many decades, there was active nurse recruitment by some NHS trusts in England and by some independent healthcare providers in Britain, and international nurse migration to the UK began to increase in 1998-99. National and international recruitment agencies were used to recruit nurses quickly from various international sources.

In 1999-2000 many NHS trusts as well as private sector employers actively and directly recruited nurses from India, the Philippines, Spain, Australia, and South Africa (RCN 2003). Some other recruitment initiatives like recruitment and retention of local nurses, and increased nursing training capacities, were also promoted. As a result of active international advertisement and recruitment, nurses from an increasing

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<sup>6</sup> During the human resources restructuring programme over 50% of ancillary posts were cut but over 22,530 general managers' posts were created to manage the NHS. This total reduction of nursing and midwifery posts was mainly because of the reclassification of trainee nurses as supernumery (Buchan 2000).

number of source countries became attracted to the British healthcare system. Gradually the number of source countries for nurse migration to Britain also started to increase. In 2002-03 one NHS hospital in London employed staff members from 68 different countries (RCN 2003). Although the inflow of overseas nurses in Britain seems to have peaked in 2001-02 the number of overseas nurses coming into Britain remained consistently high until 2006-07.

The Nursing and Midwifery Council (NMC) register in 2009 suggests that the overseas nurses' inflow to Britain significantly decreased in 2007-08. This is probably a result of many changes to NMC registration policy for overseas nurses and to work permit regulation for overseas health workers in 2004 and in 2006. In addition, there have been many NHS nursing job cuts, as NHS trusts started facing budget deficits in 2005-06. These NHS job cuts have reduced the pressure of employing more nurses quickly and finding overseas nurses to fill vacancies. This has had direct consequences on work permit policies for overseas health workers. Some media reports arose of many home-trained nurses remaining unemployed in 2005-06 (Hancock 2008). In 2006, it appeared that there were enough home-trained nurses in Britain, and the Home Office consequently removed nursing from the list of professions with skill shortages, and new regulations were made regarding work permits for overseas nurses. This change in policy has been contested by the nursing professional trade union, Royal College of Nursing (RCN). Howard Cotton, policy head at the RCN-UK, has warned the government that there is a possibility of the NHS facing a shortfall of 25,000 nurses by 2016, if today's NHS nurse recruitment and retention trend continues (Duffin 2008). With the need for more nurses, there are other pressing issues, related to the nursing workforce situation, which have been frequently highlighted and discussed, both by media and policy researchers. These are crucial issues and careful attention is needed for future workforce planning. There are some contemporary nursing workforce issues and concerns in the UK.

### *Ageing workforce*

Not only is the general population demography changing in the UK, as in most western and developed countries, but so too is the nursing workforce demography. Advancement in medical technology has improved life expectancy, and now increasing number of people live longer and many need more long-term healthcare.

There is therefore further reason to be concerned about the future supply of the nursing workforce in the UK, as this is 'ageing' or 'greying' itself (Dean 2009). The NMC record for 2007-08 shows that 31.04% of nurses in the NMC record are aged 50 and over compared to 27.30% in 2003-04 (NMC 2009). The total younger nursing workforce aged below 29 years decreased from 10.46% in 2003-04 to 9.26% in 2007-08. When a large percentage of nurses estimated to be over 200,000 out of a total 660,000, retires in the next 10 to 15 or 20 years (Kendall-Raynor & Waters 2009), there may be a yawning work-force gap, which will need to be replaced somehow. It is not just that qualified and experienced nurses are greying or ageing, but recently more mature students have entered into training than in previous years, and these mature students have probably fewer working years than younger nursing students. It would appear that younger people are not attracted to the nursing profession.

#### *High drop-out rates of nursing students*

From the late 90s, with government efforts to increase nursing student numbers, there has been a significant increase in nursing student numbers, from 16,000 in 1994-95 to 58,000 in 1999-2000. This enthusiasm, however, has not been consistent and sustained (Times Higher Education 2000). Although the total intake has increased, not all students complete their training. The nursing student drop-out rate remains consistently higher than average at 25 % of total intakes across the UK. Even after completing the training, not all graduates register with the NMC to practise as nurses. The reason for the higher drop-out, during or after training, is believed to be the nature of job shift patterns and the higher percentage of students joining nursing in their 30s, a time women usually start families and have other family commitments (Waters 2010). This high student drop-out rate was estimated to have cost 57 million to the NHS in 2006 and has increased to 98 million in 2008 (Waters 2010; BBC News 2008; BBC News 2006).

Mcgarth (2006) claims that even after qualifying, nurses are constantly in a "should I stay or should I go?" dilemma. Some nurses choose to work part-time and others leave the profession early in their working lives, while others make international moves.

### *Migration from the UK*

Nursing migration has always, to some degree, been a two-way flow of nurses (Buchan 2002). In 2007-08 there was a new development in the UK, in that the number of British nurses going out of UK exceeded the number of overseas nurses joining the NMC register. This could mean problems for the UK nursing workforce planners. The number of British nurses seeking jobs outside the UK increased significantly from 7610 in 2003-04 to 11,178 in 2007-08 (NMC 2009). If this trend continues in the future, it could have a devastating effect on the nursing workforce in the UK. The NMC statistics published in April 2009 indicate that the total nursing and midwifery stock was reduced by 12,000, within a year, by the end of March 2008, and by a further 12,000 between April 2008 to the end of March 2009: a total of 24,000 reductions in two years (Kendal-Raynor & Waters 2009). The major destination for UK-trained nurses has been Australia, USA, New Zealand, Ireland and a few other developed countries. Although the number of home-trained nurses on the NMC register has increased, for the first time in 2008, new nurses' entries to the register is less than that of nurses leaving the NMC register. From 2007-08, Britain has become a nurse donor country rather than a recipient country. Thus, British nurses seem also to be looking for better opportunities elsewhere in the contemporary global market.

This mobility and migration of nurses in many directions to varied destinations is a very prominent example of globalisation in health. No country today is untouched by nurse migration (Kingma 2006). As already discussed, quick and easy access to communication and technology and cheap travel facilities has lubricated the global movement of people. To take Nepali nurses as an example, before 2000 Nepali nurses in the British healthcare system were almost unheard of and the number of Nepali nurses in Britain was almost insignificant. But in 2000, nurses in Nepal started hearing about nursing shortages in the UK and of the British recruitment drive for more nurses. Nurses increasingly made enquiries about migration opportunities to the UK. Using their personal networks, a few nurses made their way to the UK in 2000. The rumour circulated, and more nurses started looking for British jobs as new networks and migration facilitation services started to emerge. In 2006-07, 147 Nepali nurses joined the NMC register and Nepal ranked as the 6<sup>th</sup> source country for nurses entering the UK. The number decreased to 117 in 2007-08, however, although Nepal

still remained the 5<sup>th</sup> source country from which overseas nurses joined the NMC register. This is further discussed in Chapter five (on page 155).

#### **D. Migration and mobility in the Nepal Context**

As for many other countries in the world, mobility and migration is an old phenomenon in Nepal. Even before becoming a modern Nation state in 1816, Nepal, tucked away in the high hills and great Himalayas, had been receiving foreign visitors for centuries (Lindell 1997; Liechty 1997). Not only did the area receive foreign visitors, but Nepalis also have long migrated to other countries in Asia: to India, Bhutan, and Burma. For over two centuries this phenomenon has been evidenced with the migration of seasonal migrant workers, security guards, and factory workers amongst others (Brusle 2010; Shrestha-Schipper 2010; WFP & NDRI 2008; Brusle 2007; Seddon *et al.* 2001). Some people have moved permanently. The history of Gurkhas serving in the British Army goes back almost two hundred years now. Perceived in the west as being hardy and fit, and exceptional soldiers, Gurkhas have not just worked for the British but have also worked for the Indian and Singapore armies (Caplan 1991). For decades, male labour migration, mainly to cities and to India, has been a livelihood strategy for villagers in the hills (Brusle 2007; Sharma 2007; Von der Heide & Hoffmann 2001).

In the last few decades, rural to urban migration has become an increasingly common practice in Nepal (Adhikari 2008). People from rural areas migrate to urban areas for education, for access to healthcare services and for jobs, in short for modern facilities available mainly in urban centres. One reason for rural to urban migration is that many of the educated and aspirant rural youth seek urban jobs and an urban life style (Sharma 2007). Moving to urban centres has been long perceived by many as a sign of prosperity and modernity (Leichty 2003). There are no white-collar jobs in rural areas, and there has been little government initiative and effort to retain the rural population by creating job opportunities. Additionally, nearly all major health services are urban-based, and moving to urban areas is the only way to get modern healthcare in Nepal (Harper 2003). When people need these facilities, and can afford them, they move to urban centres. Further, Nepali politics and bureaucracy are extremely centralised on the capital city, Kathmandu, and many people from rural areas are forced to come to Kathmandu for administrative and government business.

This pattern of rural to urban migration and indeed international migration has been further escalated by recent political unrest in Nepal (Gurung 2010).<sup>7</sup> In 1996, the communist party of Nepal-Maoist declared a “people’s war” (Hutt 2004; Thapa with Sijapati 2003). For almost a decade, many rural villages have become a threat for wealthy people because Maoist cadres were extorting their wealth. Many moved to urban centres for personal and family safety. Rural youths were constantly under pressure to join the Maoist army. Those youths who did not join the Maoist army have also migrated to busy urban centres where they can remain more anonymous. For all these reasons, some urban centres are massively overpopulated, while the population in some rural areas is declining (Bhattarai-Ghimire & Upreti 2008).

Rural people have not only moved to urban centres. From the 1990s, many have migrated to the new industrialising countries in Asia and to the Gulf and to wider international destinations in search of jobs and livelihoods (Brusle 2010; Adhikari 2008). Men are working as labourers in factories, construction companies and as security guards. There are Nepali women migrants in Korea, Japan, Hong Kong, the Gulf, and Israel, employed as domestic workers. This type of labour and particularly female migration for international jobs is a new phenomenon in Nepal (UNIFEM & NIDS 2006).

#### *Health worker migration in and from Nepal*

Skilled professionals, including health workers, have long been part of migration in Nepal. Even during the Rana regime (1847-1950) there were foreign-trained physicians serving the Ranas and the Royal family. After the end of the Rana period in 1951, international experts, aid workers and Christian missionaries went to Nepal to support the country in the establishment of health services and other development activities (Lindell 1997, Dixit 2005, Harper 2009; Owen-Fleming 1990). Nepal remains heavily dependent on aid, and receives substantial monetary as well as expert foreign technical assistance.

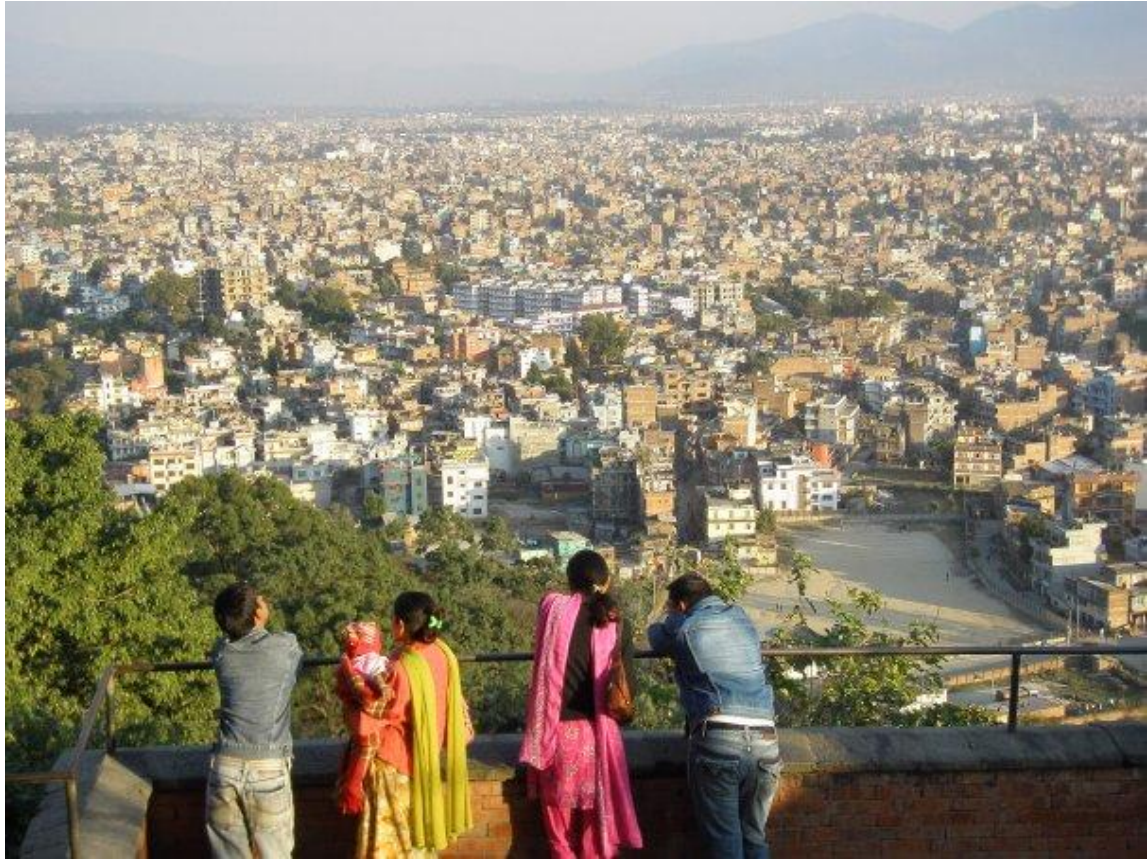
Until the late 1990s, professional health worker migration was only into Nepal. There have, however, been changes with skilled professionals moving both into and from

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<sup>7</sup> Gurung A. writes a piece entitled “a house in the city” for guest column, of Nepalnews.com. He highlights the recent rural to urban migration in Nepal, modern aspiration to live in the city.

Nepal, creating a two-way flow. Since the late 1990s, the number of Nepali health workers going abroad has increased significantly. The number of Nepali qualified nurses who have migrated abroad, until the end of 2008, is estimated as between 2500-3000, while around 500 foreign trained nurses were registered to work as professional nurses in Nepal. With the new millennium came new opportunities for Nepali health workers, including nurses, in the wider world outside Nepal. Increasing numbers of skilled Nepali professionals such as doctors, nurses and engineers found job opportunities and started to move to the USA, Canada, UK, and Australia. Nurses are part of the new generation of professional migrants shifting to the west from Nepal.

Nepal is a relatively new and small player in the field of large scale global migration. In the next chapter I look at the recent socio-political changes in Nepal and its links with female migration, before turning to the increase in health worker training capacity in chapter three.



**Figure 2.1: Rapidly growing urban sprawl. View from Syambhunath temple, looking over the Kathmandu Valley (photo by Ian Harper).**



**Figure 2.2: Migrant women at Tribhuvan International Airport Kathmandu, in the departure lounge.**



## **CHAPTER TWO**

### **NEPAL, GENDER POLITICS AND FEMALE MIGRATION**

Nepal underwent a major political change in 1951, ending a 104-year long hereditary and feudal Rana regime. For the first time in Nepal's history, multiparty democracy was established. Although the multiparty system lasted for only a decade, this political change exposed ordinary Nepalis to the wider world. Further political change occurred in the 1990s and, for the second time, multiparty democracy was established. This change allowed further opportunities for wider debates on basic human rights, development and democracy, including gender issues. Since then, these issues have become central to almost all political party promises, as well as being regularly debated in the Nepali parliament, reported by news media and being important subjects for everyday social conversation.

There has also been another shift in relation to women and the migration issue. From the time of the 'second democracy' of the 1990s, a new generation of women, in urban centres and in rural villages, has been able to participate and enjoy growing opportunities for education. Consequently, increasing numbers of young women with secondary school education began to get jobs in foreign countries, becoming active economic agents. Young women from middle-class families, particularly in urban centres, educated mostly in high fee-paying private schools, secure places in extremely competitive technical training particularly nursing. These opportunities for education and mobility for young women are new and were not available to an older generation of women. Women are now seen as family economic saviours, and migration opportunities viewed as women's freedom and independence (UNIFEM & NIDS 2006; Sancharika Sumuha & UNIFEM 2003). How and when these discourses have emerged in Nepal is discussed in this chapter. This chapter further highlights just how rapid and dramatic this socio-political change has been.

I will first briefly trace the socio-political history of Nepal, to provide the background to understanding women's position in a dominant Hindu socio-cultural context, and outline some of the reasons for the emerging phenomenon of international migration of Nepali women. Factors such as volatile multiparty democracy, new liberal economic policy, and changing livelihoods and social changes are explored. Young

aspirants looking for wider economic opportunities, as well being keen as to see the wider world, are further important and highly relevant issues in understanding female migration from contemporary Nepal.

### **A. Political history**

Nepal is a small landlocked country situated between the gigantic Tibetan plateau in the north and India to the east, west and south, with the Himalayan range acting as a natural barrier in the north. Nepal's unique geography is part of the political picture which is commonly described as "a small yam between two giant rocks"; and geopolitically, too, almost trapped between two emerging economic superpowers, China (or Tibet) and India (Malagodi 2007; Whelpton 2005; Shrestha 1997).

Nepal has altitudes and climates ranging from sea level in the southern plain to an alpine climate along the Himalayan mountain range which is home to many of the world's highest mountains: Everest, Kanchangunja, Dhaulagiri among others. The country is divided into three geographical regions: Himali Bhag (the mountainous region), Pahadi Bhag (the mid-hills and valleys), and Tarai (the southern plain). A large part of Himali Bhag in the north is uninhabitable for human beings because of geographical\_inaccessibility and its harsh weather conditions. People live mainly in the mid-hills and in the Tarai. These three regions stretch from east to west along the border with India. There are some valleys in the mid hills with major towns and cities, such as Kathmandu and Pokhara, and some towns in the Tarai which are heavily populated. The Tarai is more densely populated, given its fertile land for agriculture.

During the period when most of South Asia was under the control of the British East India Company, the Shahs were continuing their expansion mission, resulting in the Anglo-Gorkha (Nepal) war from 1814 to 1816. This war ended with the Sugauli treaty in 1816. In this treaty, Nepal lost almost one third of its territory to the East India Company. The Sugauli treaty of 1816 defined present-day Nepal's national boundaries, and modern Nepal as a nation state emerged from this treaty (Whelpton 2005; Thapa with Sijapati 2003).

There are stories of the British (or the East India Company) being very impressed with the Gurkhas' bravery in this war. Accounts of it can still be heard in Nepal and

read in history books in secondary school. After the Sugauli treaty the British started recruiting Gurkhas for their Army. When the British left India in the 1940s, they took some Gurkha regiments with them and positioned other Gurkha regiments in India. Recruitment of Gurkhas for the British and Indian Army still continues.

After the Kot massacre in 1846, there was a change of power. Jung Bahadur Rana became the prime minister. From that time, the country was ruled by the Rana family until 1951. The Ranas lived luxurious lavish lives, consuming British and other foreign goods. The Shah Kings, however, were kept as figureheads only. The Ranas maintained diplomatic relationships with the British in India. It is widely believed that this was mainly to keep their position politically safe (Whelpton 2005; Onta 1997). During the Rana rule, ordinary people did not have any education, healthcare, or any provision at all of modern-day facilities. The Rana allowed a few selected individual foreigners entry to Nepal, but for the ordinary tourist all possible avenues were closed. Apart from the Ranas and a few elites in Kathmandu, there were no roads, drinking water supply or any kind of modern infrastructure development activity in the country. From a modernist perspective, the Rana period is described as the “Dark Age” (Whelpton 2005; Thapa with Sijapati 2003; Liechty 1997; Onta 1997). Nepal, as a nation, has a long history of isolation from the rest of the world, yet the Rana rulers were friendly with the British in India.

After the end of the Rana regime, multi-party democracy was established for the first time in Nepal in February 1951. Ideas of *Bikas* (development or progress) were introduced. Dixit has described how Nepal had metamorphosed from a forbidden kingdom to a developing country. Immediately after this, foreign aid started to come in along with foreign technical support (1997: 173). In 1955 the National Planning Commission was established, with the aim of planning and carrying out economic development activities. Education, road networks, healthcare services, amongst other development activities seen today, were established in the 1950s. However, politically, this decade remained as a decade of instability that led to frequent changes of the government and political systems. In the 1960s King Mahendra took over all executive power, and once again political parties were banned. A party-less *Panchayat* system was established, and the Shah family, King Tribhuvan and his

successors, King Mahendra and his son (the now late King Birendra) , ruled the country until 1990.

*Bikas* activities, however, continued in the 1960s, 1970s and in the 1980s. Road networks increased, school and higher education institutions, and healthcare services expanded in the countryside and modern and agricultural development programmes were introduced with the help of foreign aid and technical assistance. Consequently, literacy rates rose and more rural areas became connected to urban centres by motorable roads and urbanisation continued. With the ideas of *Bikas* or development and progress, increasing numbers of the general public started aspiring for improved living standards, and white-collar paid jobs. Corruption and political mis-governance also flourished alongside these changes. Educated people became more politically aware of the King's autocratic rule and were inspired to seek multi-party democracy and freedom. Political parties, mainly Nepali Congress and the Communist Party of Nepal, were working underground, expanding and gaining increasing public support. Public protest against the *Panchayat* government began late in 1989.

In 1990, the democratic movement forced King Birendra to re-establish multi-party democracy. Many political parties, that had gone underground until then, were able to come out openly. Since then, Nepal's political system has been very unstable. There have been frequent changes of government, and each new government has been led by a different political party, almost on a 'trial and error' basis. There has been regular ideological friction within and amongst political parties, leading to breaking-up and reuniting, and a breaking-up again: the same cycle repeated several times (Thapa with Sijapati 2003; Gellner 2008).

In 1996, an ultra left-wing, breakaway branch of the Communist Party of Nepal, called the Communist Party of Nepal-Maoist (CPN-M) decided to go to war for the establishment of a 'People's Republic of Nepal'. The ruling government at the time tried to ignore the demands made by the Maoist party. But the Maoists continued their 'people's war' targeting mostly rural areas. Starting the movement from the far-western hilly district of Rolpa, they attacked the government and its supporters and many political party activists. They even established a parallel government in rural villages and set up a people's court, taking the law into their own hands. They began collecting taxes and donations to fund their revolutionary activities, quite often

terrorising locals. In July 2001, Sher Bahadur Deuba, the elected Prime Minister declared a ceasefire and initiated peace talks. Both sides agreed and had several rounds of peace talks during the ceasefire. In November 2001, however, a four months' old period of cease fire came to an end. The Maoists again began attacking government security forces. A state of emergency was proclaimed on the 26<sup>th</sup> November 2001, and the Maoists were labelled a terrorist organisation. The state of emergency was extended until August 2002. The second ceasefire was declared in January 2003 and peace talks were re-initiated. However, this attempt also failed. The Government intensified army efforts to control the Maoists, but this became increasingly bloody and violent. Many people, including Maoist guerrillas, Nepal army soldiers and civilians, lost their lives. In the 10 years' war from 1996 to 2006, it is estimated that over 13,000 Nepali people were killed. Finally in 2006, the Maoists agreed to join mainstream politics, then to conduct a general election and ultimately to end the monarchy.

After the palace massacre and the death of King Birendra and all his family in June 2001, his only surviving brother, Gynendra had become the King of Nepal. He took extreme measures to control the Maoist war and suppressed all opposition political parties. With the worsening political situation, in February 2005, King Gynendra sacked the democratically-elected government, resumed his executive power (very much as his father did in the 1960s) and declared again a state of emergency. He formed a new government, placed tighter controls on media broadcasts, suspended basic human rights, like freedom of expression, property rights and the right to privacy. Telephone lines were then cut off and all news and broadcast media was censored. Political leaders, journalists, human rights activists and parliamentarians including the Prime Minister were put under house arrest. After a period of civil unrest, the king was forced to step down and to re-instate the previous democratically-elected government. All political parties joined together to resolve the political crisis and formed an interim government in April 2006.

This interim coalition government conducted a Constituency Assembly election in April 10, 2008. At this election the Maoist Party received the majority of the popular vote, but not enough to make their own independent government. As a result, the Maoist-led coalition government was formed. The new parliament voted against the

monarchy. After abolishing monarchy the Nepali parliament passed a bill, and, on the 28<sup>th</sup> of May 2008, declared Nepal as a secular state. Until then, Nepal was the only Hindu kingdom (officially) in the world. This government ran the country for over a year, but many problems related to political power remained unchanged, and poverty and public expectations remained high on the agenda. There was a disagreement between the Maoist Prime Minister and the President from the Nepali Congress Party, so the Maoist Party pulled out of the government in early May 2009.

In May 2009, a second coalition government was formed; this time between the Communist Party of Nepal – United Marxist and Leninist (CPN-UML) and the Nepali Congress Party, with CPN (Maoist) as the main opposition party. However the political situation, as of August 2010, remains very volatile. The present government, at the time of writing this thesis (late August 2010) is firstly to write a new constitution for Nepal, then to conduct a general election. The final deadline for writing an all inclusive constitution was 28<sup>th</sup> of May 2010. As the deadline date approached, the political situation became increasingly tense. There were no clear guidelines on alternatives if the new constitution was not ready: some political parties were working towards an extension of the Constituent Assembly term but the CPN-Maoist party was demanding the Prime Minister's resignation and formation of a new coalition government led by them. Eventually, at the final hour, all the major parties came to an agreement that the Constituent Assembly be extended for another year, until the end of May 2011.

Until the 1990s, during the Panchayat period, the reason for Nepal's under-development and poverty was believed to be due to the Ranas autocratic policy. After the establishment of multi-party democracy in 1990, the feudal Panchayat system supported by the Hindu religion was blamed for all socio-political problems and under-development. National population census 2001 census suggested that 80.6% people were Hindu (Government of Nepal 2007). Present Nepali law is based on the Hindu religion and its caste distinctions. Processes of Sanskritisation or Hinduisation have been seen as one of the major causes for caste-based discrimination and discrimination against women.

Since the establishment of the second multiparty democracy in the 1990s, a new set of political parties has emerged. Some of the new political parties represent ethnic and

cultural groups. There are many other political issues still to sort out, and one of them is to decide what type of government system to suggest for Nepal. A strongly-contested issue is to propose a federal system based on ethnic groups, their language and culture. The present government (in August 2010) still has to write a new and all-inclusive constitution that accommodates various political, socio-cultural issues including women's rights.

The volatile political situation severely affected daily life in the country. People in rural areas were living in fear, feeling trapped between the Nepal Army and the Maoist guerrillas (Pettigrew 2004). Mobility and transport systems were severely affected by the *bandhas*; the general closure of shops, schools, colleges, offices, roads and transportation networks. Regular strikes, demonstrations, tyre burning in the protest of some issue or other, remain everyday news as of August 2010. It has deepened the poverty crisis in rural areas. During *bandhas*, the general public, dependent on markets for daily supplies of foodstuffs, have difficulty getting basic supplies because of an intensive security presence. During the Maoist war (from 1996 to 2006) many infrastructures such as roads, bridges, telecommunication system, school and office buildings, and power-plants were destroyed, and most development programmes were on halt. Jhimruk power plant in Pyuthan district was destroyed in 2002 (Thapa with Sijapati 2003). Lack of long-term energy planning, compounded by damage and destruction of existing infrastructure caused a severe power shortage (Shakya 2009). For example, during the dry season of 2008-09, there were up to 18 hours a day of power cuts in Kathmandu and across the country (where electricity existed). Haviland (2009) reported from Kathmandu that "Nepal becomes the land of blackouts". This has indeed affected business, industries, and many aspects of everyday lives.

According to the world development index Nepal remains one of the poorest countries in the world, with an annual per capita income of \$447 (ADB 2010). It has a poor GDP, high unemployment, high maternal and child mortality and overall poor health statistics. Its rapid population growth and environmental degradation, its heavy reliance on foreign aid and the increasing importance of foreign employment and remittances are crucial issues. Nepal had a total population of almost 30 million in 2009, with around 80% living in rural areas. Currently, the major income sources are

foreign aid, tourism and remittances from Nepali nationals working abroad (Shakya 2009), but the majority of people in rural Nepal rely on agriculture for survival.

### *Present economy and livelihoods*

Most Nepali households employ a combination of livelihood methods and have diverse income sources. Some run small businesses in addition to seasonal farming; some have formal sector jobs as well as engaging in seasonal farming; and, in some households, some members engage in seasonal farming and others migrate for remittances.

### *Agriculture*

Agriculture however has always been the backbone of the Nepali economy. The vast majority of people have relied on small land-holding and agricultural production for subsistence for centuries. Agriculture provides employment opportunities for 66% of the total population and contributed about 38 % to the GDP by the end of 2007 (WFPN & NDRI 2008). Uneducated and less-educated people and the vast majority of women in rural areas make up the majority of the agricultural workforce. Outside agriculture, very few jobs are available in the formal sector, modern industrial production, tourism and the government sector. Educated professionals living in rural areas and small urban centres, who teach in local schools or work in health centres or for local authorities, supplement their income with small-scale farming during their free time.

In addition to agricultural farming for grains, Shakya (2009) suggests that there is a potential for expansion into herbs and plant growing. Nepal has a unique topography, where the climate zone ranges from just above a sea level to a high alpine climate. There are diverse plants and herbs, and it would be possible to grow them commercially in their natural environment. This issue has been frequently discussed at policy level, but, because of the fragile political situation, a lack of modern information and technology, and poor access to markets, the business potential in this area remains unexplored and underutilised.



### *Foreign Aid*

Foreign Aid has made a significant contribution in infrastructure development since the 1950s, as already noted above. Education, healthcare, water and sanitation, road and transportation networks, and agricultural and industrial development activities are supported by foreign aid. Nepal has become heavily aid-dependent for the most public sector development activities.

### *Tourism*

Tourism as a major business and income opportunity started mainly after Sir Edmund Hillary and Tenzing Norgay Sherpa climbed Mt. Everest in 1953. It quickly became a thriving new source of income for many Nepalis living and working in tourist areas. In Kathmandu and Pokhara, new hotels were opened in the 1960s and this sector continued to grow for several decades. Since the advent of new hotels, air transport has expanded gradually.

By 1990, Nepal was receiving over 300,000 foreign tourists a year, earning 4% of Nepal's GDP, close to 50 Million USD a year (Shakya 2009). Within this sector, many offshoot handicraft industries and tourist souvenir markets started in the 1960s. By the 1980s, handmade Tibetan carpets found their own international market, and by the early 1990s, this surpassed tourism as Nepal's number one foreign currency earner (Liechty 2003: 50). During the decade of the Maoist war, the tourism business did not expand much; it was hit hard because of very frequent, irregular, unplanned *bandhas*. Tourism started to catch up again after 2006-07. However, there has been some effort by the coalition government since 2008, led by the CPN Maoist Party, to promote tourism in Nepal, and 2011 has been declared as "Nepal Tourism Year".

Although tourism appears to offer a lucrative income, the business is seasonal. It has high seasons between October and March and for the rest of year this industry is much quieter. Many people who work in hotels and as porters or trekking guides have to find additional sources of income. During the quieter months, many go back to their villages and engage in agricultural work.

## *Remittances*

There has been a long tradition of Nepali people working in foreign countries and sending money home as a livelihood strategy. People from the mid hills go to India as seasonal migrant workers. From the late 1980s, migration opportunities further away, in many other international destinations countries, such as Korea, Japan and the Middle East opened up. This has increased phenomenally since the 1990s. From that time remittance has been a major supplementary income source and livelihood. Initially many Nepalis went to these wider destinations via India (Shakya 2009). Until the 1990s, passport distribution was available only from the Ministry of Foreign Affairs in Kathmandu. After the establishment of a multi-party government, passport distribution was decentralised to district level with the aim of supporting Nepali youth's participation in the global economy (Shakya 2009; Brusle 2010). As a result, the numbers of passports distributed have increased significantly. International migration continued to increase during the decade of the Maoist war (1996-2006), and remittances surged phenomenally. Shakya suggests that, by 2007, Nepal was the fifth highest remittance-receiving country in the world with annual remittance estimated at USD 1.6 billion (2009: 161). The World Bank claims that this has made a significant impact on poverty reduction; with poverty being reduced from 42% in 1995-96 to 31% in 2003-04. Official figures suggest that remittances contribute some 15% of GDP in 2007 (WFPN & NDRI 2008), but unofficially it is estimated to be much higher than this.

These are the main socio-economic and political factors that perpetuate young Nepalis' search for international opportunities. Moreover, with an overall increase in the number of Nepali youth migrating since the 1990s, there has been a new phenomenon of female migration from Nepal. Previously, Nepali women who migrated usually did so for short periods and as dependant family members. Women's changing social position partially explains the increasing female migration from Nepal. The next section provides an overview of women and gender politics in Nepal.

## B. Gender politics in Nepal

The establishment of the second multi-party democracy in the 1990 has been a key defining moment for modern Nepali politics. Amongst many others, gender-related issues have been heavily debated and contested political issues. Increasing numbers of women from all walks of life, educated and literate and even some less educated, young and old, in urban centres as well as in rural areas, started protesting, in forms of revolutionary *teej* songs, about their oppression and about wanting equal status to their male siblings (Skinner & Holland 1998). Before 1990 this type of song would never have been heard publically.

A commonly presented scenario is that Nepali women are discriminated against in many aspects in everyday life. Although the vast majority of women in rural areas make up the major agriculture workforce (Shrestha- Schipper 2010; Des Chen 1998; Subedi 1993), they do not own land or other forms of property. When women marry they move to live with their husbands' families, and are commonly seen as being given away to another family. Education for girls has always had less priority than for boys. These cultural practices are supported by legal provisions; women do not have property inheritance rights, face unequal citizenship rights and women's mobility has always been scrutinised by society and recently by the state. Patriarchal social values, based on the Hindu religion and its caste system, have been seen as the main reason for all forms of discrimination against women in Nepal (Yami 2007; Com. Parvati 2003; Tamang 2000; Subedi 1993).

The dominant and deeply-rooted Hindu socio-cultural system places women in a number of contradictory positions, both legally and, more broadly, in relation to society and the state. From the traditional Hindu religious perspective, women are seen as powerful goddesses like Kali and Durga and millions of other extremely powerful goddesses, worshipped every day by Hindus praying for power and prosperity. At the same time women are perceived as liars and as untouchables who deserve beating (Subedi 1993). Women occupy a range of social positions from unmarried virgins like the 'Kumari' with their high social status, receiving '*daksina*', (an offering of money and gifts at a religious ceremony), to the low-status married woman, who gives '*bheti*' (offerings to those to occupy higher positions religiously) (Bennett 1983). Women are not supposed to have their own identity but rather belong

to their fathers, husbands or their brothers.

This is common practice not only in Nepal, but also in northern India, Bangladesh and Pakistan. Women often have a separate social space from men, even within the household. Women of any age socialise and spend most of their time with other women. Mandelbaum (1988) provides further insight into this. He describes how women veil and seclude themselves before men in large parts of South Asia, including Pakistan, northern India and Bangladesh, describing this region as the purdah region. He states:

A woman's personality typically matures and functions within a much narrower sphere than does a man's - more restricted in space, in activities, in social relations, in opportunities for self-assertion, power, and control. As we have noted, women are expected to be dependent on men in almost all domains and periods of life. Do they, therefore, develop dependant personalities? (Mandelbaum 1988: 43)

As Mandelbaum suggests, a young girl child in the purdah region is brought up differently from a boy. I briefly look at a woman's typical life-cycle pattern in rural – and in some urban - areas in Nepal.

### *Early childhood*

A daughter is treated differently from a son right from her birth. The birth of a daughter in a family is not an equal occasion for rejoicing as that of a son. Hindus celebrate *nawaran* or a naming ceremony, on the eleventh day after the birth, and this usually remains low-key for a girl's birth but can be a big celebration for a boy. Women who give birth to a son are treated and looked after better during their postpartum period. Baby girls usually have their first rice feeding ceremony (*pasni*) when they are five months old, but boys have this when they are six months old: sons are breastfed for longer than daughters. Looking at how families perceive illness in children and their consequent treatment-seeking behaviours, it can be seen that money spent on treatment for boys versus girls varies too (Pokhrel & Sauerborn 2004).

Right from childhood, young women are taught to fulfil a different set of social roles and family duties, but not taught their rights (Skinner & Holland 1998; Subedi 1993). Young women are prepared to marry and become good daughters-in-law and good

wives. In rural Nepal, and to some degree in urban centres, until the 1950s and 1960s and even in the 1970s, young women would be taught domestic skills such as *tapari-gashne* (making leaf plates) and *batti-katne* (making cotton wicks for oil-lamps) and to help older women in the kitchen preparing meals. A woman with fine skills in these areas would indicate that she was from a respectable household and had a proper domestic education. Women are to speak graciously, and walk around the house gently, and dress modestly (Pettigrew 2008). A good daughter is not supposed to question her parents' authority and not to be strong willed. However, sons are brought up differently from daughters and expected to fulfil different social and familial roles.

Young women are also not supposed go out on their own. A common phrase my grandmother and many women of her generation in Nepal used to say was "*chhoriko ijjet paniko phokka jastai huunchha*" - meaning a 'daughter's *ijjet* is like a water bubble, so fragile that once damaged it can never be repaired', but sons are different. *Ijjet* is commonly translated as pride and honour and a family has to maintain its honour by safeguarding the women's behaviour. For example, if an unmarried daughter is seen with a strange man this can damage her reputation for ever. For this reason, young women's mobility is controlled by the household, for protecting women's *ijjet* is seen as protecting family *ijjet*, and this is the responsibility of male family members.

Spending a night away from home, unescorted by a male family member or guardian, and marrying a man from outside her caste and culture, can ruin a woman's reputation, as well as that of her family. So, it is a parental duty to prepare a daughter for marriage and future family life within socio-cultural norms. It is very important to keep a daughter within safe domestic, as well as social, boundaries. For this reason, women's mobility is closely watched in society.

### *Marriage*

Parents feel that it is their duty to 'marry their daughter off'. Until they are officially married and handed over to another family, unmarried daughters are considered as "*paraya dhan*" or someone else's property in many parts of purdah region (Jeffery *et al.* 1989). Similarly, in Nepal women are considered "*arkako gharma jane jat*", a thing that goes away to someone else's house and "*arulai dine jat*", things to give

away to somebody else. Subedi (1993) quotes the following verses from Kalidasa's play *Avigyan Sakuntala*:

The daughter is a thing to give away, for someone else she is kept, what a relief to send her away today, I am light as feather and free from debt.

This attitude is still prevalent in some Nepali households. Parents regularly express how relieved they feel after their daughter's marriage. Nepali households are composed of a joint family group (Bennett 1983; Kaspar 2005). After young women are officially handed over to another family, they live with their in-laws.

As in other parts of South Asia, marriages in Nepal are arranged by the senior family members, kin, friends and relatives. Brides and grooms are usually matched and the marriage process is negotiated. Caste, socio-economic standing, age, the educational background of family members as well as that of the prospective couples are important issues in match-making in an arranged marriage.

The practice of dowries or bridal gifts are not as common in Nepal as they are in India, Bangladesh and other parts of South Asia, although a family's social status is judged by how much they spend on their children's marriage (Liechty 2003; Mandelbaum 1988). People usually spend a great deal of money on wedding feasts and gifts, in order to maintain their social status. For this reason too, marrying a daughter off is a relief.

In some rural villages in Nepal, child marriages are still very common (Thapa 1996). Numbers are decreasing in urban areas, as a result of changing marriage practices within broader social changes, but are still quite frequent occurrences.

### *Motherhood and women's role*

A woman's role involves mainly housework and the bearing of children first, then working in agricultural production, depending on the family's economic and social standing. As in other parts of South Asia (Jeffery *et al.* 1989), marriage and fertility are closely associated with cultural purity and pollution in many Hindu households. Menstruation is considered polluting for the woman involved. For at least three to four days during this time, women are kept separately outside the main house in Nepal. They are not allowed to enter the family kitchen or to prepare or touch family

meals. Giving birth is also a polluting time for the whole family on the husbands' side especially all of his male side of family and relatives in Nepal. Although seclusion is observed mostly by high-caste Hindus (Subedi 1993; Bennett 1983), this can be noticed amongst other caste and ethnic groups, depending on their socio-economic status and social position. Women from lower-caste households with better economic status, or women influenced by high-caste people, also practise this.

In most Nepali households, women who remain within these social norms are seen as "good women" (Skinner & Holland 1998). Their good behaviour or strict observance of these cultural practices can lift a family's social position. For many women, no matter how much society changes, they are expected to remain within socially-sanctioned boundaries: to marry only once and even if they are widowed in their early lives, they are still expected to remain widows. Skinner and Holland (1998: 92) states:

Women who deviated from the life path did so because they were intrinsically immoral or the victim of bad luck. A woman who did not have children, for example, was presumed to be barren, and her condition was attributed to her sins in a past life... widows too, had fallen off the expected life path. They had the bad fate to outlive their husbands...

Widows are expected to wear white clothes for the rest of their lives. For Hindus, white is an inauspicious colour: a sign of death and mourning.

Joshi (2001) argues that Nepali women in general, are regarded as *cheli* or kin and needing paternalistic protection. They are loved family members but with very limited rights. Most married women's mobility also is limited to occasional visits to their parents and other relatives. They are welcome in their natal home, but only with permission from their in-laws. A longer stay away from their husband's home is not seen in a positive light. Their mobility is scrutinised and strictly controlled by their families and also by society. This again is a common practice in Nepal as well as in other parts of South Asia (Joshi 2001; Jeffery & Jeffery 1997; Narayan 1997; Allen & Mukherjee 1990; Jeffery *et al.* 1989).

Women's health and wellbeing is also a lesser priority in an ordinary Nepali household. Women generally are to eat their meals last after everybody has eaten their meals. Their meal is often less nutritious and insufficient. MoHP (2009) statistics suggests that 36% of women of reproductive age were anaemic due to poor nutritional

intake. The maternal mortality rate is 281 per 100,000 births, which is higher than the average for South Asia. Only 18% of births are attended by any type of trained healthcare professionals.

Nepali communities, however, are extremely diverse, socio-culturally, linguistically and in terms of marriage practices, and the situation is rapidly changing. Variations exist within different households depending on localities, caste and ethnic groups, families' economic and social standings. For example, cross-cousin arranged marriage amongst Magar and Gurung ethnic groups is a common practice (Ahearn 2004; De Chen 1998), but this is absolutely a taboo amongst Brahmins and Chhetris. Women and men from modern liberal and educated families increasingly choose their own marriage partners.

According to conventional gender equality indicators such as literacy rates, health status, and legal and political participation, Nepali women lag behind men in almost every aspect. Despite many legal reforms, after democracy in 1990, to allow women and men equal rights, the Nepali legal system remains, in practice, patriarchal in nature (Joshi 2001; Tamang 2000). Women's rights activists argue that the dominant Hindu patriarchal system creates women as second-class citizens. Lack of women's participation in politics, poor family health status, high fertility and rapid population growth are seen as a result of women's illiteracy and ignorance (Subedi 1993). In 1997, only 7% women were employed in the formal sector and had paid jobs. The whole scenario of Nepali women's social position appears desolate. I briefly examine what legal provisions there are with regards to women's property inheritance and citizenship rights.

#### *Women and property inheritance and citizenship rights*

Nepali customary practices are supported, even to this day, by legal provisions. Although women make up most of the agricultural workforce, with only 7% women owning property, women have no parental property inheritance rights. Such legal provisions create conditions in which women are legally and economically dependent on their male family members. Although the Naya Muluki Ain (the New Civil Code of 1964) states that all Nepali citizens irrespective of caste, religion, sex and disabilities are equal before the law, this code contradicts itself by having two



different rules, one for Nepali men and one for Nepali women. Pradhan-Malla (2001) one of the leading women's rights lawyers in Nepal, argues that the lack of property inheritance rights for Nepali women, makes women economically dependent on men.

When parents die, or when they want to pass on their inheritance, all their property goes automatically to their sons, but not to their daughters. If parents have no son, traditionally their property and other inheritance goes to the father's brothers' sons, and so on, but not automatically to a daughter. There is still no legal provision for parental property passing down to a daughter. Maintenance of Hindu patrilineal values, of a man's *gotra* (family name or clan and purity of lineage) is very important, and that can only be followed by another male descendant. Family *gotra* is not transferred through women.

Further, when elderly parents die, a son is needed to perform their funeral rites so that dead parents can go to heaven. They also need an annual remembrance ceremony: *Shradhaya* (feeding the dead), to keep their soul content. This can only be performed by a son. Again, if there is no son, then a man's brother's son should perform this rite. Those who observe these religious rituals have the family property inheritance rights. These are the main traditional explanations for why women do not qualify for property inheritance rights (Chhetri 2008; Subedi 1993).

A daughter handed over to another family through marriage, will not come back to her parents' house to live and take care of her elderly parents, but must stay with her husband's family and look after her in-laws when they are old. Any property given to a daughter is therefore given away and not returned so is thought to be 'wasted'. Property given to a son is retained by the family, so is useful for the parents, and sons will also look after their elderly parents and maintain their family *gotra* and religious rituals. Daughters are not seen to be of use for elderly parents. For these reasons, many families still prefer to have sons (Chhetri 2008; Subedi 1993; Jeffery *et al.* 1989).

Issues of equal citizenship rights for women are new in Nepali politics. With regards to citizenship rights, traditionally again, women received citizenship through their

fathers or through their husbands' name after marriage.<sup>8</sup> They need male family members (be it father, husband, brother, father-in-law or brother-in-law depending on if a woman is married and who is available to come to the district administration office with them) to provide consent for applications for citizenship and passport documents. Children of women, who are not married, cannot get Nepali citizenship. Additionally children of women who are married to foreign nationals also have no citizenship rights, whereas children of Nepali men married to foreign nationals have an automatic right to Nepali citizenship.

### *Some recent socio-political changes: debates and progress*

Since the Jana Andolan of the 1990s, gender-related issues have received much more attention in Nepali politics as well as in wider society (Skinner & Holland 1998). From the 1990s, women's rights activists have been lobbying for changes in these discriminatory practices and for women to gain equal rights, mainly in areas such as property inheritance and citizenship. In terms of property inheritance rights, some developments were made in the late 1990s. An unmarried woman after the age of 35 can legally claim her parents' property, although if she later marries, she must return it to her brothers. These rights directly affect women's economic security and independence.

With regards to equal citizenship rights for women, the previous and the present governments have been debating this issue for over a decade and there has been some further progress in the mid 2000s. On the 24<sup>th</sup> April 2006 the Nepali parliament proposed an amendment of all discriminatory laws against women. In May 2006, the House of Representatives passed a resolution to end patriarchal citizenship law. Now children can obtain citizenship from their mothers' citizenship, although the law has not been fully implemented in practice.<sup>9</sup> At the time of writing this thesis (as of August 2010), women's rights activists are lobbying unceasingly for equal property inheritance and citizenship rights and seeking to influence policy in the new coming

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<sup>8</sup> Citizenship certificates are required to cross international borders, to own property and engage in official, paid jobs outside the affairs of a family. Ordinary Nepali women before the 1950s did not have much need of those documents.

<sup>9</sup> There are some clauses stating that if the father of a child is not a Nepali citizen then the child has to be born in Nepal. For a mother, being a Nepali citizen is still not enough for her child to become Nepali.

constitution. The main political parties are all also working towards equal rights and equal opportunities for women in Nepal.

Another major progress made with regards to women's social position in 2008 is that 33% of seats are reserved for women in the Constituency Assembly parliament. All the major political parties now encourage women to participate in contemporary Nepali politics.

### *Girls' education in Nepal*

From the modern 'gender in development' perspective, and the Nepali context in particular, illiteracy or lack of educational opportunity is seen as one of the main barriers for progress and equal rights for women. Next, I examine women's education in Nepal, looking at the development of the formal education system, starting from the Rana regime till to date.

Until the 1950s, public education was hardly available for ordinary people in Nepal and providing formal schooling for girls was not a priority for parents. In the early 1950s, female literacy was less than 1% in Nepal.

Available historical writing and literature suggests that there were no schools, or any other kind of institution in the country where the general public could learn to read and write, during the pre and early Rana period.<sup>10</sup> The rulers perceived that public education was a threat to their power (Chitrakar 2007; Whelpton 2005; Subedi 1993). In fact, nothing is written and mentioned in any Nepali history about education in Nepal before 1853 (Lindell 1997). The very first mention of an education system is when the Rana Prime Minister Jung Bahadur Rana visited Europe in 1853. He was very impressed with many aspects of British and European life, from Georgian-style formal gardens, mansions and transport to healthcare and education systems. After his return to Nepal, Jung Bahadur Rana wanted to set up English language sessions for

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<sup>10</sup> Not only was there no school or any kind of formal education system, but Lindell speculates that the first-ever published Nepali words were in a Nepali grammar book published in India in 1820 by some foreign Christian Missionaries, who were working there (1997: 48). The Nepali script was and still is based on Devanagari script, and is derived from Sanskrit. Christian missionaries in India when they were translating and publishing the Old and New Testaments in many different languages, also translated and published the New Testament into Nepali or, as they called it, the Nepala language in 1821. But it was not until 1912 that a further Nepali grammar *Chandrika* was published by *Nepali Bhasa Parkashan Samiti* – the first published book of Nepali.

his family and descendants within his own palace in Kathmandu. He hired British and Indian teachers. From that time, the Rana rulers and their families received private education in their palace and then were sent to India for higher education. They learned to speak English and maintained good political and diplomatic relationships with the British in India.

During the late Rana period, in 1892 the Rana government built Durbar High School in Kathmandu, where English was taught. This school was an extended version of private education at the Rana palace, but designed to reach a slightly wider group of the Kathmandu elite: mainly boys from the high priestly caste and the extended Rana families. The Ranas decided who could attend this school.

There was no other provision for anyone outside the Royal family until 1901 (Liechty 1997). Then, Dev Shamsheer, successive Rana Prime Minister, in his brief period in power, started Sanskrit Pathshalas (vernacular schools) in various parts of Nepal. These Pathshalas were exclusively for high-caste Hindu boys, and students were taught Hindu religious texts only. The number of Sanskrit Pathshalas grew slowly but later, during Chandra Shamsheer's time (1901-1929), many were closed. Although these Sanskrit Pathshalas were believed to be safer than English education, Chandra Shamsheer felt education was a threat that could undermine Rana authority. Whelpton writes that Chandra Shamsheer allegedly told King George V that the British were faced with the challenges of Indian nationalism, because they had made the mistake of educating Indians (Whelpton 2005: 83).

Apart from some Sanskrit Pathshalas and the Durbar School education, public education, as we know it today in Nepal, did not exist. If ordinary people were interested in learning to read and write, they were not allowed to do so. Nepal's modern history suggests that those who learned to read and write without permission from the Ranas were punished. Some were killed and others had their hands chopped off (Whelpton 2005). Not only did the Ranas prevent ordinary people from obtaining education, but, except for a handful of ruling family members, English education was perceived by Hindus as education from an outside world. The English language was perceived as being spoken by people who eat beef. So it was called 'beef eaters' or 'cow eaters' language. The cow is sacred in Hindu religion, and those who eat cows were seen as being directly disrespectful to Hindus. The language they spoke,

therefore, would not have been desired by orthodox Hindus (Chitrakar 2007; Subedi 1993).

Education for women is not mentioned in this period of the history of education in Nepal. Indeed, until the late 1980s, some orthodox Hindus in Nepal believed that women should not read the Hindu religious text *Bhagwat Gita* on the grounds that, if a woman reads this text, she would go mad. There are still some Hindu Pathshalas and a Hindu University in Nepal, but no female students or teachers there.

Only Maharanis and Rajkumaris (queens and princesses) during the Rana period had private teachers in their palaces. For women from ordinary families, not only were there no schools, but they seem almost invisible in the written history of Nepal prior to 1928. The few women encountered in the history books were a small number of royal and aristocratic Rana women. The first educated women recorded anywhere in the history of Nepal were Vidhayawoti Kansakar, Radha Devi Malakar, Dharma Devi Kansakar and Bishnu Devi Mali. They were the women sent to India for nursing and midwifery training in 1928 (Singh 2007; Maxwell with Sinha 2004; NAN 2002). Their level of education is not mentioned anywhere. It is notable that these women were not from ordinary families but from families who were religiously motivated or had members who were political activists. In Autumn 2008, I managed to learn a bit about Vidhayawoti Kansakar and her family background from her family friend, an elderly teacher in Kathmandu, who knew Vidhayawoti Kansakar's younger sister. He told me this:

Vidhayawoti's father, Dayabir Singh Kansakar was a political activist, and Vidhayawoti was unmarried and a Buddhist nun. During the Rana regime, Dayabir Singh Kansakar was one of the few Newari writers in Kathmandu. He was actively involved in Nepali politics seeking to overthrow the Rana regime. He believed in girls' education and he taught his daughters at home. He wanted Vidhayawoti to become "Nepal's Florence Nightingale".<sup>11</sup>

Towards the end of the Rana period in the 1940s, the Rana Prime Minister Mohan Shamsheer Jung Bahadur Rana adopted a slightly more liberal attitude to women's education. In 1947, the first school for girls was established in Kathmandu. Tuladhar,

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<sup>11</sup> Telephone interview with Mr Subanaman Kansakar, a retired teacher in Kathmandu, in Autumn 2008.

a specialist in gender and education in Nepal, reports that, before 1950, people believed that if a “woman is educated she would be a witch” (2007: 106).

Although the idea of female education began in the mid 1940s, the main push to promote education for girls and boys alike began only after the end of the Rana regime and the establishment of democracy in 1951 (Subedi 1993). It took many years for the new government to establish the necessary infrastructure and encourage the general public to send their children to school. During the 1950s new schools were built in urban and district centres, all heavily supported by foreign aid. Politicians and educationists had to go around the country campaigning for schooling for children. There were only a few schools for girls at that time and there was no socially-sanctioned profession for women outside the conduct of their family affairs. There were very few educated women in the country and some of them were educated abroad. A few widely-known educated women were: Punya Prabha Dhungana, Mangala Devi Shrestaha, Sahana Pradhan and Pushpalata Pradhan. Sahana and Pushpalata Pradhan were sisters. They were part of the Nepali Diaspora in Burma and they received their basic education there. When the Burmese government expelled ethnic Nepalis after the Second World War, they returned to Nepal. Mrs Joshi, who was a third group nurse graduate in Nepal, reflects on her early schooling experience;

... We were young and lived in Ilam, in the eastern hill of Nepal. It was in the early 50s, we did not go to school as there was no school for girls in the district, and there were no girls attending school anyway. My father was a local merchant, and our house (and shop in the ground floor) was in the village centre. We helped our parents in doing housework and running our shop. We girls used to wear kalli (big thick silver anklets).<sup>12</sup> I remember one day a man came to our village from some distant part of India called Assam. He was a Nepali man but had lived in India. He stayed in our house that night; he talked to our father later that night and requested my father to send us to school. From the next day he went around the village and started requesting people to send their children to school. He started a school in our village. He was the first person I remember who introduced school education in our village. We called him “Joshi Sir”. He gave us extra tuition at home. My elder sister and I were enrolled in class four straight away. There was no female teacher. A few years later there was a nationwide education campaign. Then two women came to our village from Kathmandu to promote girls’ education, and they were encouraging women to take up the teaching profession. These women, too, stayed in our house, as it was the only decent house in the village where outside visitors could stay. Later I learned that one of them was Mrs Sahana Pradhan and the other one was her sister.

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<sup>12</sup> She said this hesitantly as this type of heavy and thick jewellery is now perceived as old-fashioned or indigenous or tribal fashion, not of fine quality and modern design.

They were Burmese Nepali and were educated in Burma.<sup>13</sup> A few years later, when we were in our secondary school, my sister and I undertook a teacher's training course and my sister remained in the teaching profession, but I joined nursing later.<sup>14</sup>

Although this is just one person's experience, it provides some insight into women's education and the social situation of the 1950s.

As part of wider development processes, nursing education began in the mid 1950s, but there were few educated women in Nepal suitable for nurse training. Maxwell with Sinha (2004) gives us further insight into this. Given a lack of educated girls to recruit for nurse training, the United Mission to Nepal (UMN) had to advertise in Darjeeling, India. Gradually, female literacy figures started improving. Juanita Owen, an American nurse who went to Kathmandu in 1954 to look at the feasibility of setting up and starting a nursing programme wrote;

...they [referring to Nepali families] feel it is a lowering of their moral standard to allow their girls to take up nursing... I have talked with a dozen or more families and only two have given partial consent...one of the girls...comes from a high caste family but she has had very little formal schooling. She seems quite capable...  
(Quoted in Maxwell with Sinha 2004: 7)

Around this time, only women from high-caste and socially affluent families would have any schooling at all. As already described, women from ordinary families would be prepared for marriage before they reached puberty, when they would move to their in-laws, and participate in agriculture and domestic work. Until the 1950s, women who obtained any sort of formal education were certainly not from ordinary families, but were from a small and privileged group. By 1961, female literacy was 1.8% while male literacy stood at 16.3% (Tuladhar 2007). Girls' education for ordinary families began to take off only in the 1970s with the implementation of the New Education Plan in 1972. With the help of foreign donors, the numbers of primary and secondary schools increased considerably across the country. This effort was supported by many 'Women in Development' governmental and non-governmental initiatives after the International Women's Year of 1975, including those that mobilised women in development. Aid money started coming into the country for female literacy,

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<sup>13</sup> Sahana Pradhan became one of the very senior Communist Party of Nepal (CPN) - Unite Marxist Leninist (UML) leaders. Her sister was married to Man Mohan Adhikari. The late Man Mohan Adhikari was one of the short-term Prime Ministers after the multi-party democracy of 1990, from the CPN- UML.

<sup>14</sup> Interview with Mrs Sabitri Joshi, August 2008, Kathmandu, Nepal.

empowerment, savings and credit, and income generation programmes (Subedi 1993). Consequently, female literacy rates improved and more women started to become involved in politics and work in government and non-government sectors (Liechty 1997).

There has been phenomenal change even with girls' education since 1990. Firstly, access to education has increased; the number of primary and secondary schools has increased across the country and there has been a rapid growth of private schools in urban centres. The middle-class and modern consumer culture has increased in urban centres. Middle-class parents especially value education, and are prepared to invest as much money as they can afford in their children's education. Increasing numbers of middle-class parents now send their children, sons and daughters, to private schools. The whole education system has been transformed since the 1950s, when English education was almost a taboo and seen as 'cow-eaters language'. As Liechty points out, a common perception is that the standard of education depends on how much is paid for it: "the higher the tuition fee, the better the quality of English instruction... English proficiency is simultaneously the key to a better future, an index of social capital and a part of the purchase price for a ticket out of Nepal" (Liechty 2003: 213). Shakya (2009) highlights how this "English-speaking generation" started being produced from the 1990s. This is particularly relevant to contemporary Nepali society, as the majority of nurses come from middle-class families from an English-speaking generation.

Other forces are emerging, mostly in urban Nepali society. Liechty (2003) argues that a new urban "middle-class" society sprung-up in Kathmandu after Nepal's second experiment with democracy in 1990. He argues that modern "social class" is more relevant and important to urban people now than belonging to the old caste system, and people are constantly working towards the "middle-class space". This is a "space in the middle": not high or low in terms of economic status, and not too westernised but not too traditional either. The old "Hindu" caste system is contested by, and in many cases superseded by, this modern "class" system. This middle-class society is embedded in a new consumerist culture, reflected particularly in the consumption patterns of modern and foreign goods.



Comrade Parvati claims that many rural women are still economically, culturally and socially oppressed. They have less educational and other training opportunities compared to their urban counterparts. They joined the Maoist war in order to get equal rights and treatment with male members of society (Com. Parvati 2003:165-182). Others have supported her claim that the Maoist movement in Nepal has opened up opportunities for rural women (Onesto 2005; Pettigrew 2008). Since the Communist Party of Nepal-Maoist (CPN-M) launched its People's War in 1996, one of the most significant factors for rural women has been that many young women, mostly with some education (at least primary school and some with secondary school education) have actively participated as guerrillas, as messengers or supporters in the war. Sharma and Prasai report that "in 2001 Maoists organised a guided tour for Nepali and foreign journalists to the areas under their control... and it was reported that women constituted between 30 to 40% of the Maoist cadres" (Sharma & Prasai 2004: 152). Li Onesto also provides numerous examples of rural women who joined the Maoist party. Some felt that they could occupy equal status and enjoy equal rights inside the party; where male comrades carry out tasks traditionally seen as "women's work". Some women joined the party to run away from arranged marriages, and other forms of social oppression (Onesto 2005). This has opened up more opportunities for rural women outside the domestic sphere. The Royal Nepal Army now recruits females and this is rumoured to be because of the CPN Maoist party's female cadres (Pettigrew 2008; Com. Parvati 2003).

Anthropologist Laura Ahearn has witnessed further important social changes in rural areas, consequent upon education and literacy programmes (Ahearn 2004). These too reflect broader social changes. All seems to be very different now in the new millennium. The national average female literacy has improved phenomenally, jumping from 25.0% in 1991 to 42.5% in 2001 for those aged six years and above (Tuladhar 2007).

### **C. Nepali Women and International Migration**

As more women become educated, social perceptions of women's equal rights to mobility have changed. Roads, television networks, phone connections reach wider remote districts and women become more exposed to the outside world and see new images. Transportation enables village people to come to the district centres.

Educated young women aspire to modern lifestyles and seek modern paid jobs. Very few paid jobs exist in the formal sector in Nepal. Consequently, aspiring educated women have started to look for opportunities beyond their social and national borders. Increasing numbers of women are more mobile than ever before, working away from their homes. In addition many less-educated women are working abroad as maids, nannies and domestic workers.

However a new set of state-prescribed rules and policies emerged in the 1990s with regards to women's mobility. Although in the 21<sup>st</sup> century, women are encouraged to engage in full economic participation by taking jobs in Nepal and beyond, yet, at the same time female migration has been problematised.

In February 1996, there was a high profile police raid in one of the red-light districts in Bombay in India, where hundreds of Nepali women were rescued, amongst whom 218 of whom were minors. It was believed they were victims of trafficking.<sup>15</sup> Bombay Metropolitan Police contacted the Nepali government with the intention of sending these young women back to Nepal. However, the government remained silent and took no action at all. These women were therefore kept in a temporary rescue centre in India: it was a dismal situation (Fujikura 2003; McGirk 1997). At that time in Nepal, no government department was responsible for dealing with such a situation, or indeed any gender-related issues. In the absence of Nepali government interest, some women's rights activists, and non-governmental organisations (NGOs) played a crucial role, forming an alliance of NGOs and bringing these women back to Kathmandu. The government was heavily criticised by both national and international media, NGOs and women's and human rights activists for its apparent apathy in dealing with the situation. This event led to major social and political unrest in Nepal. As a consequence, the Ministry of Women, Children and Social Welfare was established to deal with such issues. Gradually, Nepal-India border security has become tighter and all Nepali women travelling to India since this incident are strictly

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<sup>15</sup>Whether these women were trafficked to India or not remains heavily debated. I conducted a small piece of research looking at these women's broader health and social needs and the Nepal government's strategies to address them, as a part of MSc policy report for the London School of Hygiene and Tropical Medicine in 1997. I visited areas in Nepal from which many women went to Bombay. From some focus groups and discussions with young women and parents in several communities it was revealed that many women, both young and old, wanted to go to India to escape from dire poverty in these areas; wanted to see a 'modern world' and indeed had family support (Adhikari 1997).

monitored by Nepali border security. This policy remains in operation and it is supported by *Maiti Nepal*, an NGO that works in the women's development sector. It is designed to protect Nepali women from being trafficked to India.

The women rescued in Bombay in 1996 were not only sex-workers but were tested for HIV there, and many were found to be HIV positive. On many other occasions, Nepali women, found to be HIV positive, have been sent back to Nepal by Indian brothels and police. Not all returnees are rescued by NGOs, and some have died after returning home. The women from Bombay, however, were eventually taken to Nepal and housed in newly-established rehabilitation centres. Many NGOs, involved in women's rights and advocacy, criticised the government's lack of willingness to support these women, and the women's families for ignoring these critical issues. This news spread like wildfire in Nepal. For some years after this, women's migration became synonymous with trafficking and bringing back HIV/AIDS to the country. The rumour ran that these women were a risk to Nepali society. Returnees were seen as "soiled goods", "HIV/ AIDS risk group" "rotten apples", and a major embarrassment to their families and to the Government of Nepal. Some of these women were not accepted back by their families, and the government was very reluctant to rescue and rehabilitate them back to Nepal (Fujikura 2003; Joshi 2001; McGirk 1997; Adhikari 1997). After this incident, labour migration (especially to India), has been pathologised. Labour migration has directly been associated with HIV/AIDS, which then became the "Bombay disease" in rural and urban Nepal (Fujikura 2003).

In March 1998, the government of Nepal made a parliamentary decision to ban Nepali women travelling to the Gulf countries for jobs. This was a political effort to manage the public anger after a young Nepali woman, Kani Sherpa, died in the Gulf. Kani Sherpa was working there as a house-maid. It was widely believed she had been a victim of severe domestic abuse and repeatedly raped by her employer and his family members. Her death became headline news in Nepal for weeks, creating a great deal of social and political tension, which in turn put pressure on the government to do something about her death. At that time, there were already thousands of young Nepali men and women working in the Gulf, with a continuous migratory outflow

from Nepal.<sup>16</sup> The government decided to ban women from travelling abroad to work, on the grounds that women seemed more ‘vulnerable’ to exploitation and should be kept at home and protected (UNIFEM and NIDS 2006; Sancharika Samuha & UNIFEM 2003).

A third critical event relating to Nepali migrant workers abroad was equally unfortunate, but on this occasion related to Nepali men. In July 2004, twelve Nepali migrant workers were captured by the Army of Ansar al-Sunna group in Iraq and a few days later were beheaded. These men were accused of helping the US authorities in Iraq. The Ansar al-Sunna army reported that it had, “carried out the sentence of God” against them, but BBC News reported that these men were there working as cleaners and cooks (BBC News 2004). They were simply migrant labourers, not political spies for the US government. Very disturbing photos were published by both national and international media. This incident again caused major street violence in Kathmandu. The Nepali government placed the blame on manpower agencies for recruiting and sending Nepali men to unsafe places (BBC News 2004). The offices of a few manpower agencies supplying Nepali labour Gulf countries were attacked and burned down by angry gangs in Kathmandu. This resulted in religious tension between dominant Hindus and minority Muslims for weeks. Eventually, all the anger settled, but no new policy relating to control over men’s migration to the Gulf was introduced by the government.

Although the above incidents are very tragic, the government’s reaction to them has been gender-biased. Their most controversial act was to place a ban on women going to the Gulf for jobs. Women’s rights activists argue that banning or controlling women’s mobility violates women’s rights to mobility. This ban was heavily criticised because it did not stop women travelling to the Gulf but simply drove them underground.

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<sup>16</sup> Exact data are not available as there is no systematic recording system in Nepal to look at the total figures of migration from the country, and also there has been no comprehensive research conducted to look at this phenomenon. The UNIFEM and NIDS (2006) report on Nepali women and foreign labour migration estimated that 78,308 Nepali women were working abroad, excluding India, in 2006. The total number of Nepali women in India is not known. It has been widely suggested that there are 100,000-150,000 Nepali women working in Indian brothels (Joshi 2001;).

When women began to be stopped and harassed by immigration officers at Tribhuvan International Airport in Kathmandu, they started travelling to the Gulf countries via India. It is regularly reported that there was much exploitation at every step of the migration journey from Kathmandu to the destination country. Travelling to the Gulf via India takes longer, and becomes more expensive with an increased risk of being exploited en route (Pun 2004). Many women paid brokers for services, but were left stranded in Delhi Airport (en route to the Gulf). There were stories of women being sold in India by the brokers. The exact situation is not known, but migration researchers and women's rights activists suggest that the number of women going abroad has not decreased, even after the government tried to place bans on women's migration. There was a constant pressure on the government to lift this ban on women's mobility, from women activists and human rights groups. Finally the ban was lifted in 2001 and there was a week-long media campaign, to promote a more positive image of female migration (Sancharika Samuha & UNIFEM 2003).

With increasing remittance monies entering the country, women's independence and economic empowerment are the major arguments made by the women involved, their families and women's rights activists to support an increasing outflow of a female labour force. Around 11% of total remittances is contributed by women migrant workers (UNIFEM & NIDS 2006). There has been much debate and many policy suggestions to the government to take an active role in providing women with basic skills training to enable them to work abroad. The government however, has not taken any action to promote and facilitate female migration.

Negative discourses related to female migration have gradually shifted now to more positive media representations, associated with women's empowerment and providing opportunities for women to come out of poverty (Sancharika Samuha & UNIFEM 2003). Since then the Nepali authorities have been, albeit passively, supporting female (as well as male) migration. Research done by UNIFEM & NIDS (2006) indicates that Nepali women working abroad as nannies and domestic workers are usually educated to secondary level and the majority of them have full family support, financially and socially. The number of women migrating to Gulf countries, the Middle East, South Korea, Japan, Hong Kong for domestic jobs and the number of professional nurses migrating to the UK, USA and Australia and New Zealand is

increasing yearly. This is very apparent now in Tribhuvan International Airport in Kathmandu, where hundreds of Nepalis depart every day, with women migrants constituting a significant number (Brusle 2010).

### **Conclusion:**

This chapter has presented a brief socio-political introduction to Nepal and discussed Nepali women and their changing social position. In the last fifty years, there has been a major transformation in women's position in society. Female literacy has improved and social attitudes toward women's education have changed from "if women are educated they become witches" to "daughters' education is a family asset". Many schools for girls exist with wider choices of public and private education in urban centres, and greater provision for those who can afford to send their daughters to school. An increasing number of women, mainly from middle-class families, are out and about, and holding paid jobs.

At the same time, women's mobility has received mixed reactions. On one hand many people have embraced women's earning power. Women have become more mobile with greater economic power and act as economic agents. But on the other hand, the government is controlling women's mobility by tightening border security. The Nepali state still reacts in a patriarchal way when women are faced with any incidents, and quite differently when similar incidents occurred with Nepali men. For example in March 2009, nepalnews.com reported that young Nepali female students were found getting involved in the sex trade in Australia. The Nepali envoy to Australia reported this incident to the Nepal government and suggested the Nepali government consider this issue seriously (Nepalnews.com 2009a). Women are constantly watched by the Nepali media, and on many occasions young women working in the public sphere are sexually harassed by men. Incidents such as 'eve-teasing' (sexual harassment) have increased since young women started taking jobs outside their domestic sphere, and Liechty describes this "as paying for their liberty and modernity" (Liechty 1996).

Nepali women working in developed countries such as the UK and the USA appear to be more respected in society than those working in the Gulf (UNIFEM & NIDS 2006). Nursing, as we shall see, has become central to this. It has become one of the

most desired professions for women, and in particular, nursing migration is seen as a golden opportunity for women. Once perceived as an inauspicious colour, a nurse's white uniform is no longer considered so, but is a source of family pride. From the mid 1990s many middle-class parents are no longer anxious about sending their daughters into nurse training. There is no lack of interested candidates for training, and nurse daughters are seen as family assets. This changing attitude is directly related to a growing demand for nurses internationally. What is clear is that nurses are becoming active agents in international migration opportunities for the whole family and this development will be fully explored now in Chapters Three and Four. I will begin by looking at the history of professional nursing in Nepal from its beginnings until the present day.



Figure 3.1: Second year student nurses in 1982

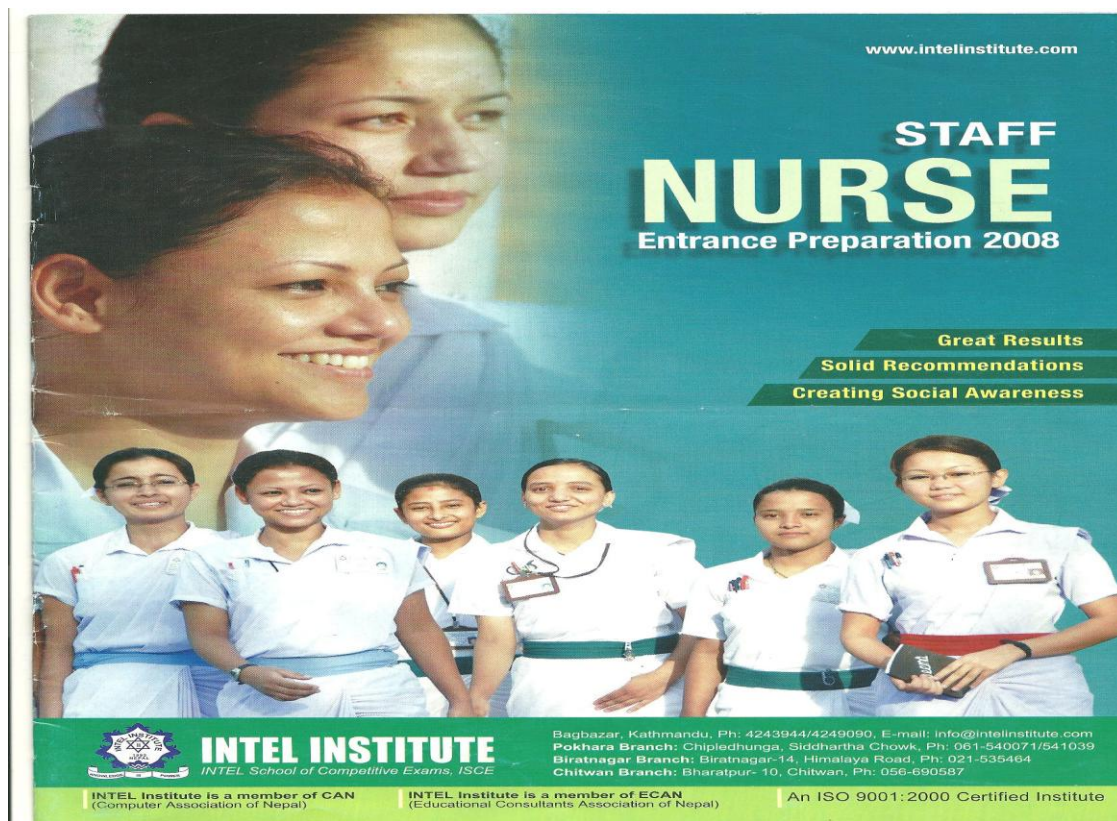


Figure 3.2: Aspirant nursing students, Intel brochure, 2008



## CHAPTER THREE

### PROFESSIONAL NURSING AND THE HEALTHCARE SYSTEM IN NEPAL

This chapter focuses on professional nursing in Nepal, mainly in relation to nurse education and its contemporary political economy. It begins by tracing the professional history of nursing and charting its development to date. This is discussed in three stages: before 1951 and the pre-establishment of professional education; between 1951-1990 as the period of establishment and development; and finally the period of privatisation and the rapid expansion of professional education which occurred after the Jana Andolan in the 1990s, and which has continued till the present.

There have been many changes within the profession since the 1990s. There has been a phenomenal expansion in training capacity and an increase in applications for nurse training. Nursing is becoming an increasingly attractive profession and, for many, it has been seen as a means to access foreign jobs or move abroad. Not only are young women and their families attracted to nursing, but there are increasing numbers of new stakeholders emerging every year. Nurse education has become a private sector business and new economic opportunities around the profession have been thriving. After highlighting this, the chapter will look at professional regulation and why many today do not regard working as a nurse in Nepal as an attractive option.

#### A. Evolution and development of the profession

##### *Nursing in Nepal before 1951*

To date there are only two written histories of nursing in Nepal: *Nurses were needed at the 'Top of the World'* by Maxwell with Sinha, published in 2004, and *History of Nursing in Nepal*, published by the Nursing Association of Nepal (NAN) in 2002.<sup>17</sup> Apart from these, there has been very little research exploring the history of nursing in Nepal. Other pieces of literature do mention nursing but within the broader context of the introduction of western medicine in Nepal.

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<sup>17</sup> This section draws heavily on these accounts, and is supplemented by interviews with some of the key senior nurses and other people who lived through these times.

All the available literature suggests that the history of the nursing profession in Nepal is intertwined with the emergence of western allopathic medicine. The first official state-run allopathic medical services for the general public in Nepal were sited in Bir Hospital in Kathmandu, established in 1890 by the Rana Prime minister, as a noble work. At that time, the Royal family and a few high-class social elites had their own healthcare providers: personal attendants and nannies, private western-trained medical doctors and local Ayurvedic practitioners (Dixit 2005; Leichty 1997). Bir Hospital began with 15 in-patient beds for male patients and a dispensary. Some years later, though the exact date is not clear, 15 more beds were added for female patients. The hospital was run by male staff only; they were called dressers (because they changed wound dressings), and compounders (who dispensed medicine). According to published works on the history of nursing and medical services in Nepal (NAN 2002, Maxwell with Sinha 2004; Dixit 2005), for 38 years, after the Bir Hospital was established, there were still no female staff to care for the patients there. Whether any female patients went to hospital for healthcare is not known either. The first reference to nurses was in 1928, when the Ranas perceived the need for female staff. Four Nepali women were sent to India for midwifery training (Maxwell with Sinha 2004; NAN 2002), accompanied by their male guardians, because it was not acceptable for women to travel on their own. They completed their training and returned to Nepal eighteen months later in 1930. Upon return, they were posted to work in the Bir Hospital in the female ward. Over the next few years more women went to India for similar training.

In 1933, the Civil Medical College was established at Bir Hospital to train dressers and compounders. Nine women were enrolled in the first group trained here. The qualification or level of education for this training is not mentioned in the published literature. A number of these women were also later sent to India for midwifery training and, when they returned to Kathmandu, they were posted to the Bir Hospital as the previous midwives had been. Bir Hospital, then, was staffed by locally trained *dressers* and *compounders*, India-trained midwives and staff from Bengal India, which is the present Bangladesh (Dixit 2005; Maxwell with Sinha 2004).

*Period of establishment and early development: 1951-1990s*

Nurse education only began in Nepal in the mid 50s and after the major political changes of 1951. In this period, nurse training programmes were established and gradually upgraded and expanded, but all under the auspices of the state-run Tribhuvan University (TU) and heavily subsidised by the state. Following the end of the Rana regime and Nepal's self-imposed isolation, the new government of Nepal, led by King Tribhuvan, had a more liberal attitude towards foreign aid and development, and the government opened its doors to foreign assistance. For the history of nursing, the missionary presence was particularly important. Christian missionaries, who were already working in neighbouring India, "preaching, teaching and healing" (Lindell 1997; Fletcher 1965), were then allowed to come to Nepal to help the new government develop healthcare and the social infrastructure (Harper 2009; Lindell 1997; Fletcher 1965).

A key event was the arrival in Nepal, in 1951, of the US administrator, Mr. Paul Rose, with his pregnant wife. Rose found no qualified midwives to assist his wife during birth. He requested a qualified and experienced western-trained midwife from the British High Commission in Delhi, India (Maxwell with Sinha 2004; NAN 2002). A midwife called Juanita Owen was sent to Kathmandu to assist the Roses during the birth of their baby. Ms Owen felt that there was a pressing need to start training nurses and midwives in Nepal and made a recommendation to His Majesty's Government of Nepal and the World Health Organisation (WHO) to set up a nurse training programme. This request was agreed by the Government and the WHO sent two British nurses to Kathmandu to start preparing for the training (Maxwell with Sinha 2004; NAN 2002).<sup>18</sup> Preparation began in 1954 and training started in 1956. Later another nurse/midwife joined the team to teach midwifery. She was from Canada and worked for USAID. Three foreign nurses had three Nepali counterparts. This training started in a rented house in Chhetrapati, Kathmandu.<sup>19</sup>

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<sup>18</sup> I have met with one of these early Nepali nurses who was trained in India, and she claims that it was her initiative. She requested the King and then government of Nepal to set up a training programme in the country. She also said that she acted as a kind of a private nurse for the Royal Family and that she visited America with King Tribhuvan and his wives.

<sup>19</sup> Interview with Mrs Lahmoo Amatya, in Kathmandu, one of the Nepali counterparts for the WHO nurses, 10<sup>th</sup> of August 2008.

As Maxwell with Sinha (2004) state, Dr. Bethel Fleming with a team of three nurses, all of whom were Christian missionaries, sent by a mission in India, also came to Nepal. The Government permitted them to begin medical work in Nepal. The United Mission to Nepal (UMN) was established and started delivering health services in 1953, in the first instance maternal and child care clinics in the Kathmandu valley. In 1956, UMN set up a hospital called Shanta Bhawan Hospital. They rented an old Rana palace and started offering health services, but they needed assistants. In 1957, three locals, two men and one woman, were selected for training in order to assist in running the hospital. These three trainees completed their three-year training course and were awarded Hospital Certificates. In January 1959, Margaret Fleming, a missionary nurse who had previously worked in India, started Shanta Bhawan Hospital (SBH) School of Nursing, located first in Surendra Bhawan and later moved to Nir Bhawan, next to the Shanta Bhawan Hospital. Initially, most students for nurse training in SBH were from Darjeeling and Kalimpong in India.

The HMG School of Nursing and Shanta Bhawan Hospital School of Nursing remained the only two institutions for training nurses until the mid 1980s (Maxwell with Sinha 2004; Thakur 1999). Both programmes had a very challenging start, and for decades, very few Nepali women were attracted to the profession. Firstly there were only small numbers of educated women in Nepal, mostly from the Kathmandu valley and from other major urban centres. Education for women then was a luxury for urban elites and affluent families and there was no intention to equip women to work outside their family and become economically independent.

Secondly, mobility was a major issue for educated women and their families. The vast majority of parents would not be accustomed to the idea of their daughter leaving home and moving to somewhere else for training or to work as a nurse.<sup>20</sup> For many rural people, nursing and a modern western-style healthcare service were alien concepts. The vast majority of people, in rural as well as in urban areas, did not have

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<sup>20</sup> Justice's research, in the late 1970s, highlights the failure of the ANM programme to deliver Maternal and Child Health services in rural areas. The main cause was related to poor socio-cultural acceptance of modern healthcare system. She found that traditional healthcare systems had existed there for centuries and so people trusted local *Sudeni* (Traditional Birth Attendants or TBAs). They would normally be mature local women, married with their own children. In contrast the ANMs were usually young, unmarried, with no personal experience of raising families. They were urban-educated with very little familiarity with rural people's lives (Justice 1986). She also highlights that for ANMs and their supervisors, district public health nurses, based in district centres, mobility was a major issue related to their jobs.

any access to modern healthcare services and modern healthcare workers. They did not exist in the most remote districts until the mid 1980s. So, for great numbers of people, there was no need to prepare a daughter for a career outside their own family.

Further, hospital-related jobs were considered culturally polluting for many high-caste Hindus (KC 2004). Accepting food cooked or prepared by any outsider and transporting cooked food around was, and still is, ritually unacceptable for many Hindus. After any length of hospital stay, or spending any length of time outside their community, many people would perform a ritual cleansing ceremony at home, and at least have *sun-pani chharne* (sprinkling of gold-dipped water) to become socially and religiously acceptable again (Harper2010; KC 2004; Liechty 1997). Additionally, nurses from the early days recount that nurse training in Nepal did not attract many candidates, because nurses wore white uniforms, the colour worn by Hindu widows. This further highlights the complex socio-cultural context that made finding candidates for training a challenge for the training authority. Not only were hospitals considered inauspicious, but the nursing profession was considered ritually unclean, so very unsuitable for high-caste Hindu women from affluent socio-economic family backgrounds. Mrs L. Amatya, one of the counterparts for the WHO nurses, shared her experience. She told me:

I was born and brought up in Darjeeling and went to Calcutta Medical College for nursing training. I met my husband there; we got married and came to Kathmandu. My husband was then working in the Royal Palace. When there was a chance for me to work with the WHO nurses, my mother-in-law said no, I should not work as a nurse and I should not wear a white uniform. White is a colour worn by Hindu widows. My husband was still alive, and so it seemed very inauspicious. My mother-in-law was very unhappy, she said “my son is alive and you should not wear a white Sari”.<sup>21</sup>

In the HMG School of Nursing, almost all the early candidates were from the Kathmandu valley, whilst the UMN programme received most of its candidates from Darjeeling and Kalimpong, India (Maxwell with Sinha 2004). As Maxwell with Sinha (2004:17) stated in their book:

UMN had issued a call for workers in their new hospital to the Christian community across their eastern border in Darjeeling and Kalimpong India.

They report the nurse trainers had to go around looking for suitable candidates: there

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<sup>21</sup> Interview with Mrs Lahmoo Amatya, the first WHO nurse counterpart, 10<sup>th</sup> August 2008, in Kathmandu.

were no particular selection or recruitment criteria. Any woman who had at least eight years of schooling, or could read and write well and was interested in joining the training course, would merit a place. Foreign nurses did not speak Nepali, and local young women did not speak English, so Nepali counterparts (available only from the HMG School of Nursing) acted as translators for the whole process as.<sup>22</sup> When the programme first began, there were only ten to twelve students in each group in the HMG School of Nursing and six to seven in Shanta Bhawan School of Nursing (NAN 2002). The intake in both schools was sporadic and opportunistic in nature. For example, three candidates who began training in the second batch in the HMG School of Nursing were later amalgamated with the first group.<sup>23</sup> In the next batch there were ten candidates. A senior nurse from this third batch in the HMG School of Nursing explained:

I was interviewed for the training, and they told me that I was successful in the interview but had to wait until there were enough candidates to make a group. I waited and waited for that. It took them a full six months to get ready and start the programme. I was so worried; I came from outside Kathmandu and was staying in our family friend's house for six months.<sup>24</sup>

I was told a similar story in 1998, by a senior nurse who was in the second batch at the UMN nursing training. She revealed that the nurse trainer went around districts outside the valley in a helicopter, as a part of a campaign to attract young women to join nursing.<sup>25</sup> Additionally the nurse trainers had to negotiate with candidates' guardians and parents, and reassure them that it would be safe for their young daughters to join the training programme and stay in students' hostels (Maxwell with Sinha 2004).

These first groups of nurses trained in Nepal qualified in 1960. Training institutions were not only responsible for training itself, but also, for the complete wellbeing and security of all student nurses. Developing this broader security for the student nurses was one way that these institutions attempted to persuade families that the profession was an acceptable one into which to send their daughters. A very senior nurse, from the third batch, commented:

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<sup>22</sup> Interview with a third batch nurse from the HMG School of Nursing, Kathmandu, August 2008

<sup>23</sup> Interview with a third batch nurse from the HMG School of Nursing, Kathmandu August 2008.

<sup>24</sup> Interview with a third batch nurse from the HMG School of Nursing, Kathmandu, August 2008.

<sup>25</sup> Conversation with a second batch nurse, SBH School of Nursing in 1998.

It used to be like a contract between the parents and the training authority that parents send their daughter for training, and in return, the training authority would provide them with a safe and protective environment. All student nurses had to stay in a hostel with no access for any outsiders and their letters were censored to make sure that they were not having communication with anybody [particularly men] outside their families.<sup>26</sup>

In the 1960s, as part of the national development programme during the *Panchayat* era, education for all children, including girls, was encouraged. Gradually more girls, particularly from urban areas, but also some from rural districts, started attending school. Slowly literacy rates started to rise. This had a major impact on nurse training. After the first few batches of trained nurses entered general employment there were significant changes in perception. Mrs Joshi recollected her early experiences:

... these early nurses were deemed *smarter* [meaning intelligent] than ordinary women in Nepali society, and they had relatively good earnings. Even during the training period we would get some pocket money, and we started getting opportunities to go to foreign countries for further training.

Mrs Joshi qualified in 1962 and in 1963 she was given a scholarship for further Public Health training in Beirut.<sup>27</sup> Many of these early nurses obtained scholarships to study abroad and later received respectable positions under the Ministry of Health, as there were so very few qualified nurses.

By the 1970s, the number of young women completing School Leaving Certificate (SLC) level education increased further and more women, and their families, became interested in nursing. The few training programmes that existed began to receive better-educated candidates, and to have some choice for selection. Until 1972, nurse training was run by the Ministry of Health. Then nurse training was moved under the umbrella of Tribhuvan University (TU), which came under the direction of the Ministry of Education (Maxwell with Sinha 2004; NAN 2002). As a consequence, nursing became university level education: proficiency certificate level (PCL), and not just a professional vocational training. Another significant event in the mid 1970s, was that HRH Princess Prekchhaya entered nursing. Thus nursing became not just a university degree but a profession that could even be considered by the royal family, which acted as a good advertisement for many people.

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<sup>26</sup> Interview with Mrs Joshi, a third batch nurse, qualified in 1962, 10<sup>th</sup> August 2008.

<sup>27</sup> As well as Beirut, others went to Lebanon and India, funded by the WHO and USAID (NAN 2002).

By the 1980s the profession was becoming more accepted, but there were still only two Staff Nurse Colleges in the country, with the capacity to train 50 nurses a year. By this time, there were five Auxiliary Nurse Midwife (ANM) extension colleges in the districts.<sup>28</sup> These were then upgraded to staff nurse programmes as part of an improvement programme to raise the professional standards of nursing. By the end of 1989, ANM programmes were upgraded and six SN training programmes existed across the country (Maharajgunj, Pokhara, Nepalgunj, Birgunj, Biratnagar, and Lalitpur Nursing Campus). The first college had by now become the ‘mother campus’ run by TU, and was based in Maharajgunj, Kathmandu. The second college, known as Lalitpur Nursing Campus was independent, administratively and financially supported by the UMN, but has been academically under TU since 1972.

*The period of privatisation and rapid expansion: post 1990s Jana Andolan*

Professional nursing has transformed rapidly since the 1990s. Although the idea of privatisation emerged in the late 1980s, it remained in the background until the establishment of the Council for Technical Education and Vocational Training (CTEVT) in 1989, which introduced the private sector into technical education provision. As a result of privatisation, there has been a rapid increase in private colleges since the late 1990s. The training capacity has grown so fast that there has been a shortage of academic staff and clinical placement facilities to cope with the demand for these resources. News reports about a lack of hospital beds and about the quality of nurse teaching, increasingly moonlight teaching, have raised crucial issues about training quality and regulation. As a result, new regulations for professional training have emerged.

By the academic year of 2008-09, five levels of nurse education were available in Nepal: from ANM to MSc Nursing. A brief outline of each of these is provided below.

1. *The Auxiliary Nurse Midwife (ANM).* There were only five ANM programmes in the country in the early 1980s all under the TU. After the programme was taken over by the CTEVT, the number increased to 40, all

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<sup>28</sup> This research does not explore the training details of ANM programmes



under the CTEVT and set up in the 1990s. This course is currently run by institutions affiliated with the CTEVT. Today there are 40 institutions around the country (over half are in Kathmandu). Opportunities for ANM work are available throughout the hills in rural areas, as well as in urban areas. Initially, ANM training was for two years. When the courses were started, in the late 1960s, any young woman who had passed grade eight at school could apply for this state-run training. Many who did not have the requisite SLC pass and were unable to apply directly for the staff nurse course saw this as a route to becoming a staff nurse, as, to pass the ANM training qualified one to apply for staff nurse training. Indeed many senior nurses in Nepal traversed this very route to their current positions. This remains the case today, even though the entry requirements for ANM training have risen to an SLC pass, since the training was discontinued by TU and responsibilities were transferred over to CTEVT.

2. *The Proficiency Certificate Level in Nursing (PCL) or Staff Nurse.* Prior to the establishment of CTEVT, there were six staff nurse campuses in Nepal (Maharjanganj, Lalitpur, Biratnagar, Pokhara, Nepalgunj and Birgunj Nursing Campus, all under the purview of the state). They trained a total of just over 250 nurses per year. The idea was to train enough staff nurses for the district centre hospitals and other government hospitals through the country. This was consequent upon a review of the nursing curriculum in 1987, and the need to include primary healthcare concepts in nursing training (Thakur 1999). Currently, there are unregistered training colleges opening each year and a few have been closed recently. While exact figures are not available, my interviews and data-gathering estimate that about 1,565 staff nurses are trained annually from thirty nine institutions<sup>29</sup>: thirty of these are registered under the CTEVT, of which only one is not private; six are affiliated with the TU, Institute of Medicine, one is registered with Kathmandu University, one with the Bir Hospital, and one with BP Koirala Institute of Health Sciences in Dharan.

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<sup>29</sup> This number will change from 2011 as five new programmes started in 2008.

3. *Bachelor of Science in Nursing (BSc. Nursing)*. Seventeen programmes in the country have received university affiliation: one in the TU, IOM in Maharajgunj; eleven are affiliated with Purbanchal University; three are affiliated with Kathmandu University (in Dhulikhel, Banepa, and Kathmandu); one is run by BP Koirala Institute of Health Sciences (BPKIHS) in Dharan and one is affiliated with Pokhara University. The first BSc. nursing programme was started at the BPKIHS in Dharan in 1993 and remained the only one for over a decade. The programme was attached to BPK Memorial Hospital. They started with an intake of only ten students a year. The early graduates were mostly employed by the training hospital and some by nurse training institutions (nationally). In the decade following, as the private sector in Nepal began to become more involved in health workforce training, more BSc. nurse training programmes opened. These courses are four-year courses, and are accessible only through 10 plus 2 years in Science from school.<sup>30</sup> The rationale for these courses is to produce nurses better versed in science and, in part, to allow nursing as a profession to compete with medicine.
4. *Bachelor in Nursing (BN)*. The route to this level of training is after three years of PCL training and three years' working experience. This degree used to be run by TU, having started in 1976. Currently post-liberalisation, there are fourteen BN programmes, three under the Institute of Medicine (Maharajgunj, Lalitpur and Pokhara); ten affiliated with Purbanchal University (nine in Kathmandu valley, one in Biratnagar); and one in the Bir Hospital nursing campus in Kathmandu.
5. *MSc. in Nursing*. By the end of 2009, there were three Masters Degree programmes in nursing available in Nepal: in TU, IOM Maharajgunj, in BPKIHS, Dharan (from 2008 only) and the final one started in 2009 at Lalitpur Nursing Campus. This is aimed at those who want to teach, for which plenty of opportunities are emerging.

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<sup>30</sup> School education in Nepal is ten years long (School Leaving Certificate), and then an additional 2 years with science major is called 10+2 science.

Table 3.1 provides summary details of the numbers of students, varieties of nursing programmes, training capacities and affiliations.

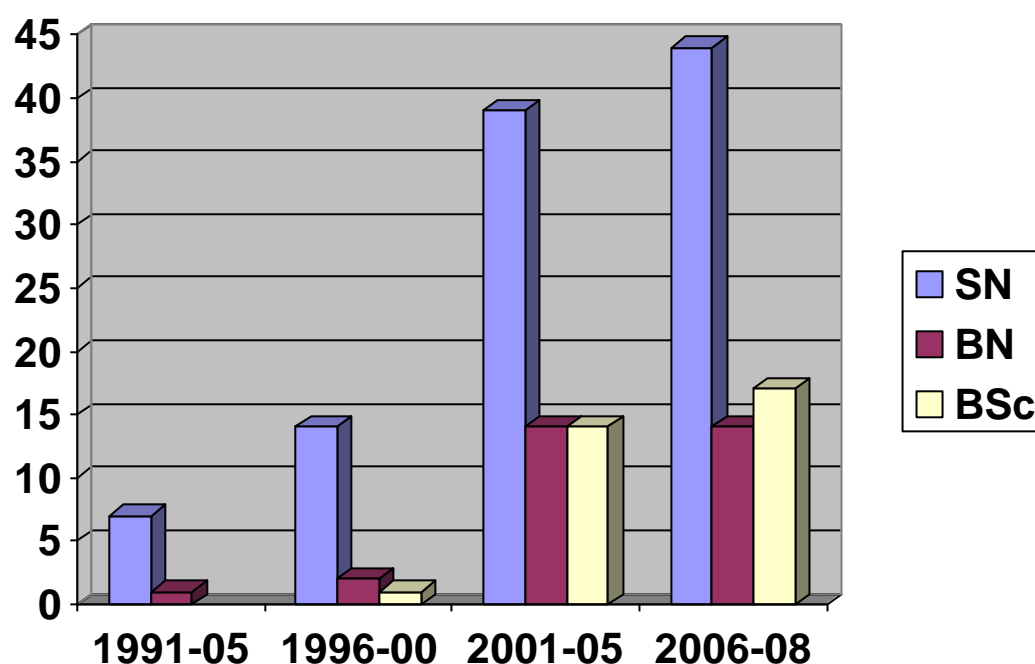
**Table 3.1: Overview of total nursing training programmes in the 2008-09 academic session.**

| Nursing Programme        | Total number of colleges | Affiliation with  | Training capacity   |
|--------------------------|--------------------------|---|---|
| ANMs                     | 40                       | CTEVT   | 40 each   |
| Staff Nursing            | 39                       | 30- CTEVT<br>6- TU<br>1- NAMS Bir Hospital.<br>1- BPKIH, Dharan<br>1- KU, Dhulikhel             | Mostly 40 each but there are colleges which take between 35-45 students in a group. |
| BSc Nursing              | 17                       | 1- TU Maharajgunj<br>3- KU<br>1- PU<br>1-BPKIHS, Dharan<br>1-Pokhara University (Nobel College) | 20 each   |
| Bachelor in Nursing (BN) | 14                       | 3-TU<br>10- PU<br>1- NAMS (Bir Hospital NC)   |   |
| MN                       | 3                        | TU- MNC, started in 1996<br>BPKIHS, started in 2008<br>Lalitpur NC, from 2009                   | Started with an intake of 4 per year but is presently 12 per year                   |

In this thesis, I focus mainly on the SN and BN courses (as post-basic training) and the most recently designed BSc. nursing programmes and discuss these two streams of nurse training. These programmes have been designed with the purpose of equipping nurses with qualifications, not just for nursing in Nepal, but also with international nursing opportunities in mind. As we shall see, these have been the fastest growing programmes. Graph 3.1, below, illustrates the current growing trend of nursing training programmes since 1991.

**Graph 3.1: Growth of Nurse training programme since 1991 (SN, BN and BSc).**

Source: Radha Adhikari, research fieldwork.



There are two main reasons for this rapid growth in training capacity. First there is a high demand for more training places. With increases in female literacy in the country, nursing has become an attractive profession. In 2007, for example, BPKISH in Dharan received over 1900 applications for 40 staff nurse training places. Similarly, the Bir Hospital Nursing Campus in Kathmandu received over 3000 applications for 40 places, while one of the TU-run colleges in Kathmandu received 548 applications for 45 training places. This demand has been catered for by the private sector training colleges under the auspices of the CTEVT.

In the 1980s, many nurses faced opposition from parents and grandparents, but young women who want to join nursing face less opposition nowadays. For example, in Autumn 2008, I met Rita who worked as a housemaid for an expatriate family in Kathmandu. She had two grown-up daughters and an elderly mother; all were economically dependent on her earnings. Her elder daughter was at University, studying for a degree in Arts, and the younger daughter was in the second year of nurse training. When she learned that I was a nurse, and researching into Nepali nurses and international migration, she became very keen to talk to me. I, too, wanted to talk to her daughter who was a student nurse. But the conversation was dominated

by Rita as she wanted to explore the migration possibilities for her daughter when she finished training. Rita shared her concerns with me this way:

Gita wanted to do nursing, so first she applied to go to government-run nursing colleges [believed to be better and cheaper]. She tried in Birgunj Nursing Campus. I took her there, I went with her. She tried in Bir Hospital Nursing Campus. I took her there. She tried four or five other places, but had no luck. She was still determined to join nursing. Finally we had to apply to a private college. She got a place there. She is in the second year of her training now. The fee there is very expensive and it is a big commitment for me. I have to pay total 3-4 lakh Rupees [approximately £2500- 3500 depending on exchange rate]. I work hard to save this amount ...

Finally she said her daughter wanted to go to Australia to work as a nurse, and she asked me if I could advise them or suggest an easier route to international jobs.<sup>31</sup> This is very common in urban centres now. Nursing opportunities abroad have been seen as the most desirable opportunity and a passport to a foreign job. Staff Nurse training curricula have been adjusted and new types of training programmes have been set up purely to cater for this aspiration.

#### *Adjustment of training curriculum to meet international nursing needs*

Tribhuvan University revised their nurse training curriculum in 2006-07 and all nursing colleges in Nepal adopted this new curriculum. Care of the Elderly and Psychiatric Nursing modules have been added to the existing curriculum, however the total teaching and training hours have not been adjusted or expanded. This means some time is now taken away from other modules.

A professor of nursing involved in the curriculum development told me this was to equip Nepali nurses to work in the USA and UK. Once Nepali nurses started migrating to the USA and to the UK, nurse training colleges in Nepal began receiving letters from American and British nurse licensing authorities, mainly to verify Nepali nurses' training. Initially, colleges received just a few letters a month, but, by 2002-03 they were receiving dozens of letters every week, reflecting the increasing number of Nepali nurses trying to register with foreign nurse licensing authorities.

Two nursing college Principals in Kathmandu realised that, in many instances, the total training hours were insufficient according to US guidelines. They felt they had to

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<sup>31</sup> Personal communication with Rita in November 2008, in Kathmandu.

falsify or exaggerate their former students training hours as they were already in the USA or in the UK looking for nursing jobs. Without official verification letters from their training colleges, they would not be able to gain full professional licences to practise as nurses, and ultimately find nursing jobs. The Principals of Nursing Colleges realised their former students' vulnerability. On the one hand they wanted to support their students, and, on the other hand, they were aware of the shortfalls in certain aspects of nurse training. They felt that perhaps the training did not cover all the areas of nursing needed for work in the USA and in the UK. They continued to provide training verification letters to foreign authorities. Some senior nursing academics on the curriculum development committee met and decided that it was time to adjust the Nepali nursing curriculum, as they expected that nurses would continue to migrate anyway. In terms of developing a training curriculum in Nepal, the TU-run nursing college in Maharajgunj has been the "trend setter", the "mother campus", with private colleges follow the trend.

Nursing professionals in Nepal identified that the key areas of concern for the foreign nursing authorities, related to the Care of the Elderly and Psychiatric nursing training credit hours and students' clinical exposure in these areas in Nepal's staff nurse training. Nepali nursing colleges were regularly required to write to the British and American licensing bodies, to verify and give details of how much psychiatric and geriatric training Nepali nursing students had undergone, in both theory and in practice.

Both specialities had not been taught previously in Nepal in much detail. However, as regards to psychiatric nursing this is mainly in the education sector. A care of the elderly module is not directly applicable in Nepal's context, as elderly people are still looked after at home by their extended family members. To date, there is no Care of the Elderly department within Nepal's healthcare system.

#### *New BSc. nurse training programme*

Completely new types of nurse training have been introduced in Nepal with the intention of training nurses for the global market. Nepal's new BSc. nurse training clearly illustrates this point. I asked a co-ordinator for the BSc. Nursing programme in one of the government-run institutions why this training is needed in Nepal, as not a

single position is planned for BSc. Nursing graduates in the government-run health service. Where are the jobs for these BSc. graduates? The coordinator's reply was:

...this is to improve the nursing standard in Nepal, bring it to international standards by teaching more science, and prepare nurses who are fit for the global market.<sup>32</sup>

With this global market in mind, starting a nurse training programme is now perceived as a very profitable business venture by the increasing number of individuals and organisations investing in the proliferating private health sector. The BSc. training started mainly after 2004-05. At the time of this research, it had been viewed as the most suitable training for the international supply of nurses as they would be better versed in scientific modules. The BSc. nurse graduates could not have been intended for domestic supply, as no job existed, nor has any post been created within the government health system. When I visited the Ministry of Health to enquire about the future jobs for these graduates, I was told that there had been no joint planning between the trainers and the employers; between the Ministry of Health and Population of Nepal and the hospitals and organisations who employ nurses.

I went on to meet with BSc. nursing students themselves and asked them why they wanted to study BSc. nursing. The majority admitted that they would look for international opportunities.

## **B. Major stakeholders in nurse training: their roles and professional partnerships**

### *The Council for Technical Education and Vocational Training (CTEVT)*

Since its establishment in 1989 the CTEVT has been one of the main players in professional nursing, involved in training ANM and Staff Nurses in Nepal. This is an autonomous umbrella organisation, whose main aims are to formulate policy and coordinate with all technical education and vocational training programmes in the country. In 2008, there were hundreds of courses ranging from the short-term, Technical School Leaving Certificate (TSLC) to Diploma-level training in

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<sup>32</sup> Interview with a BSc. Nursing Programme Coordinator in Kathmandu August 2006.

Agriculture, Health, Engineering and Hospitality and Management areas affiliated with CTEVT.<sup>33</sup>

The new democratic government of the 1990s encouraged the private sector to become involved in technical education and vocational training courses. In 1994, after a major restructuring in the health sector, the then government predicted that there was a need for 4000 ANMs in the country (NAN 2002). Initially, the private sector was encouraged to set up ANM programmes to meet this need. Within a few years, the number of ANM training programmes rose from zero to up to forty, with a significant increase in training programme for other categories of health workers. The ANM programmes remain at forty. However, by 2000, there was a surplus of fully trained ANMs. The government did not create enough positions to absorb them all and, as a result, many trained ANMs remained jobless. There was no further demand for ANM training places so the number of ANM training programmes levelled off.

Conversely the number of staff nurse programmes started to rise from 2000, from seven colleges in 2000 to over three dozen by 2008 (all under the CTEVT), and the number grew further in the 2009 academic year. This increase raises many questions: how do private colleges gain CTEVT affiliation to start a training programme? How does the CTEVT manage and coordinate all these programmes and what of the crucial issue of professional standards?

Unfortunately, no formal study has yet examined why so many emerged so quickly. However, from informal discussions with stakeholders, listening to opinions and talks, and from reading journalistic publications, it would appear that this growth is linked to the demand for more nurse training places. Applicant numbers are apparently increasing each year (no national cumulative figure is available) but the CTEVT exam section director told me this:

The application number is increasing every year, the market is demand-driven, and there are opportunities for Nepali nurses internationally.<sup>34</sup>

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<sup>33</sup> All technical (as well as academic) teaching and training programmes have to be affiliated with either the CTEVT or a University in Nepal. There are institutes that run more than one programme, for example Staff Nursing and Bachelor's degree in nursing programme; these programmes are affiliated with two different institutes; SN programmes are with the CTEVT and BN with a University.

<sup>34</sup> Interview with the Deputy Director of CTEVT Accreditation Division in October 2007



In order to find out how business investors set up these colleges, and how they relate to the CTEVT rules, regulation and policy guidelines, I interviewed the Deputy Director of Accreditation Division of the CTEVT. He explained how a training institution is awarded CTEVT accreditation in practice for starting up a new programme. The steps and process are briefly outlined below:

1. An interested party submits an application with a full proposal to the Council.
2. The Council's Accreditation Division then reviews this proposal, and, if it seems appropriate, they write to the Nepal Nursing Council with a request for a feasibility study and their report.
3. The Council's Accreditation Division conducts a feasibility study, according to the very clear criteria of the Nursing Council and CTEVT as to what is required for each programme.
4. The CTEVT carries out the feasibility study and the Nursing Council has another independent study done and sends the report to the CTEVT.
5. The CTEVT Accreditation Division makes a decision considering the Nursing Council's report.

In theory, an institute that has met *all* the required criteria receives an initial five year accreditation. If there are matters needing improvement, the proposed programme can be given a year to bring the programme up to the required standard. All applicants and institutions should meet certain criteria based on the human and physical resources available to run a programme.

According to the Deputy Director of the Accreditation Division, a proposed Staff Nurse programme should have full access to a minimum of a 50-bedded general hospital in order for students to learn clinical nursing skills. If the programme does not have its own hospital, it should provide a contract for the use of clinical placement facilities and should build its own hospital within the next two years. In his experience, all the nursing colleges under the CTEVT meet these criteria.

He stressed that the second most important issue is the teaching faculty. All programmes should have, as the Principal, someone with at least a Masters Degree in nursing or, failing that, they should employ someone with a BSc. in Nursing plus at least five years of teaching experience. The Deputy Director, however, admitted that

this is a very difficult issue for many private colleges, as there are not enough nurses qualified at Masters level in Nepal.

...there is a shortage of MSc. nurses here in Nepal. So, we have many programmes run by BSc. or BN qualified nurses.<sup>35</sup>

The third criterion is that all programmes should have their own buildings with enough physical space for teaching and academic activities. If not, they should provide evidence that they have a contract to use a building for teaching and learning activities for at least three years. Within this period, they are expected to procure their own building. All programmes should also have enough support facilities; necessary equipment; library facilities; and hostel facilities for students.

Finally, if a programme is Kathmandu-based, it should have five ropani of land.<sup>36</sup> Outside the valley an institution should have ten ropani of land to run a nurse training programme.

### *Management issues and difficulties*

These CTEVT-prescribed criteria seem fairly straightforward, but the Council has been criticised and faces considerable difficulty in making institutions adhere to the minimum criteria. Since all training responsibilities were handed over to the CTEVT in 1989, no single government department is directly responsible for training numbers and the quality or standard of training programmes. TU staff, Ministry of Health staff, and many in senior government positions simply blame the CTEVT for the deteriorating standards in nurse training. All private colleges come under the CTEVT, and although there is clear policy on affiliation and accreditation of a nurse training programme, the capacity to regulate and implement the regulations is very weak. Many colleges have been criticised for not meeting these basic minimum criteria. In many cases criteria are manipulated by the institutions. They are presented on paper, but once the programme receives accreditation, there may be no full-time Principal in post, and providing students with clinical placement facilities is always a huge challenge. When I asked the Deputy Director of the Accreditation Division in CTEVT about this, he admitted that human resources and clinical placement facilities are

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<sup>35</sup> Interview with the Deputy Director, CTEVT Accreditation Division October 2007

<sup>36</sup> A particular land measurement used in Nepal, eight *ropani* is almost an acre of land.

usually the major problems in private colleges.<sup>37</sup> CTEVT guidelines are obviously not implemented in practice. These guidelines were designed in 1989, when fewer colleges existed, so they might have been easier to implement then. Now, however, CTEVT has not got the capacity to effectively implement them.

My ethnographic observations also suggest that there is a lack of communication among the various divisions at the CTEVT. For example, if a new programme comes to the CTEVT Accreditation Division, with a proposal to start a new campus and presents a full proposal on paper, the Accreditation Division completes a feasibility study and approves the accreditation needed to set up a programme. Its job is then finished. The Accreditation Division is responsible only for overseeing if a *proposed* programme meets the required minimum criteria. If these are in place during the feasibility study time, then the programme will be approved to start training. There are colleges, however, where staff turnover is so rapid that it is quite possible that a full-time Principal would not be in post the next day. Furthermore, monitoring and evaluation are done by a different division and the Accreditation Division has no further role, not even one of communication and co-ordination. A Research and Information Division exists in CTEVT. During my research visit there, in October 2007, there were only two staff members in the office chatting to each other. They admitted that, to date, no research had been conducted by this division since its establishment. No research evidence exists to help formulate policy.

The CTEVT faces several other difficulties. It has been accused of being very corrupt, is known for taking bribes, and staff have been accused of abusing their power. I heard many stories of CTEVT staff involvement in students' exam results. Students pass exams despite a lack of academic achievement, if they are prepared to bribe the external examiner, who is appointed by the CTEVT Examination Division (Rai 2009; Harper 2003). From the personal accounts of many students, collected during this research, it would seem that the external examiners have been paid large amounts of money collectively, so that all students receive 'pass' results. Several students and faculty members said that the external examiners regard the exam period as a "harvest time". Additionally when CTEVT staff conduct a feasibility study to set up a new

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<sup>37</sup> Interview with the Deputy Director of Accreditation Division, CTEVT, October 2007

training programme (in nursing or any other technical school) they are also regularly bribed by the applicants.

A private nursing college lecturer told me:

A proposed nursing college should have two independent feasibility study reports, but they seldom match, because of this, there are some colleges who have CTEVT accreditation but no approval from the Nepal Nursing Council. But these two agencies use the same set of criteria for their feasibility study, and come out with different results.<sup>38</sup>

She suggested that the Nursing Council reports are more valid than the CTEVT reports as CTEVT staffs frequently falsify study reports.

The CTEVT also underwent a period of internal re-programming and conflict in 2006-07. When I started this research, there was a demonstration every day for several months, by students from colleges under the council demanding that their degrees receive equal recognition to the degrees from the TU. When I spoke with a group of these students, demonstrating in the Maiti Ghar area in Kathmandu in August 2006, their collective comment was that they had been treated like “second-class health workers” after the TU graduates. There were protests by students from most privately-run colleges teaching nursing and other health science subjects under the CTEVT. Moreover, the CTEVT chairperson’s office had been padlocked by the staff union, as they were unhappy about the appointment of the new chair. At this critical stage, all CTEVT activities were suspended.<sup>39</sup> Despite all these issues, more colleges obtain permission to start new programmes every year. In 2008, five new colleges in the private sector received CTEVT accreditation.

#### *Private universities and colleges, and teaching hospitals*

The CTEVT is responsible only for middle level technical and vocational training, such as staff nurse and lower level training. There are private universities and academies of medical science which have emerged in the 1990s, offering university level education such as BSc. Nursing, BN and MN. Presently (in 2010) there are three

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<sup>38</sup> Personal communication with a private nursing College Lecturer, in Kathmandu in November 2008.

<sup>39</sup> After several months negotiation in 2007 the situation improved. A new chief was appointed, and it was agreed by the Ministry of Education that CTEVT graduates would receive their degrees on an equal basis.

private universities in Nepal, namely Kathmandu University (KU), Purwanchal University (PU), and Pokhara University, all directly involved in nurse training at various levels. Although they are managed privately, they all come under the purview of Ministry of Education and Sport. All have recently started new four-year BSc. Nursing and Bachelor in Nursing (BN) courses, as these are considered higher level university degrees. Three further institutions do not yet have full ‘university’ status, having achieved Academy of Medical Sciences status, they have been authorised to run health workers’ training programmes and to issue their certificates independently. They are BP Koirala Institute of Health Science (BPKIHS), Dharan; the National Academy of Medical Sciences (NAMS) in the Bir Hospital, Kathmandu; and Patan Hospital, Academy of Medical Science. Private sector institutions with vested interests are now seeking opportunities to upgrade their programmes to university status. For example, Patan Hospital in the Kathmandu valley achieved Academy of Medical Science status in 2008, and MBBS training officially started in autumn 2009, with a view to upgrade it to “Patan University Teaching Hospital” in the future. I visited Khowapa Bahu Polytechnic Institute in Bhaktapur in November 2008, where they were running a staff nurse programme. The director of the nursing faculty informed me that they also have a vision of upgrading it to be Khowapa Bahu University.

The higher education market is expanding rapidly but with little proper regulation and control. In theory, the Nepal Nursing Council (NNC) is the professional regulatory body for nurse training and is supposed to monitor all developments and maintain professional standards, but it seems fairly ineffectual. The present situation in the private sector training institutions within the CTEVT and new private universities and colleges appears poorly thought-through and uncoordinated, and the Ministry of Health and Population has neither the responsibility nor any mechanism to deal with this chaos.

### **C. Political economy of nurse training in Nepal**

In autumn of 2007, during my fieldwork in Eastern Nepal, a nurse lecturer informed me that nurse training had indeed become a *pakka ghata nakhane business* or truly a “profit making business” or “a business that does not go into loss”. This indeed is evident from the rapid expansion of new training programmes since the start of the

new millennium. The far-reaching political economy of the nurse training business locally, nationally and internationally merits closer view.

The magnitude of the annual economic turnover of this business is not known, and this research could not make a comprehensive assessment. Nevertheless, based on the recent increases in the numbers of private training institutions, private teaching hospitals, nursing homes, and the other emerging side businesses, one can assume that it is a thriving business. It appears that there is money to be made at every stage of nurse training and the consequent migration processes. To start with, an increasing number of middle-class parents send their daughters to private schools and pay extra private tuition fees so that the young women pass their School Leaving Certificate (SLC) exam with higher grades. After the SLC is gained, they start the application process for training. Today, the majority of potential and interested candidates enrol on the widely-available Staff Nurse Entrance preparation courses, which are offered on the market for a fee. After students enrol in nurse training, there are many other layers of business opportunities, not only in nurse training fees but in relation to many additional costs and offshoot businesses. After nurses graduate, further business opportunities are focused around international nurse migration. These will be discussed in Chapter Four.

#### *Staff Nurse Entrance Exam preparation courses*

From the early 1990s, nursing colleges began to receive increasing numbers of applicants with better SLC results. In the 1980s, most nursing students had second division SLC pass scores but, by the 1990s, more applicants were academically better qualified. In order to select the best academic students, TU introduced an entrance exam in 1993, in addition to the pre-requisite second division SLC. This entrance exam is now a requirement for all Staff Nurse and BSc. Nurse training today. This exam was designed to test candidates' knowledge in English, Maths and General Health Science. As the entry requirements became tougher, students started to prepare better for the entrance exams. Within a few years of the introduction of the new entrance requirements in 1993, dozens of institutes had sprung up, offering private entrance exam preparation courses. These preparation courses are available in Kathmandu and in many urban centres across the country where nursing colleges are

located. The exact number of these institutes in the country is not known but I estimate that there are a few dozen in Kathmandu Valley.

Intel is one of the oldest and most talked-about institutes, and I will look at this as an example, to illustrate how this business works. Located in Bag Bazaar in Kathmandu, the institute was started in 1995. As well as specialising in nursing entrance exam preparation, it offers tuition in a range of other areas.<sup>40</sup> It has a very impressive website, with the most comprehensive and up-to date information on the nurse training programmes available in Nepal, including the timetable of entrance exams for particular nursing programmes; the total intake; entrance exam and admission criteria; the number of programmes and related issues. It also publishes regularly updated brochures regarding nurse training programmes. These are glossy publications with pictures of young, modern, successful-looking nurses on the front cover and photographs of *all* of their successful candidates inside. In addition, posters are placed on electricity posts on major street corners and junctions in Kathmandu.

In the summer of 2008, the Intel website stated:

...so far, more than 1800 students from Intel have been able to clear the entrance test conducted by well-known nursing colleges. Today many of these students are established nurses in Nepal and abroad.<sup>41</sup>

Intel staff I interviewed in autumn 2008 confirmed that their business was increasingly strong. Intel's Staff Nurse Entrance Exam preparation course lasts three months and costs 4500 Nepali rupees (approximately £40 depending on exchange rates). They teach Science, English and Maths, for four hours a day and have practice tests on Saturdays. The staff explained that the business is seasonal, consisting of a high season, starting in June and July soon after the SLC results are published and running to the entrance exam period at the end of October each year. Their low season is in November and December until all colleges have enrolled their new students. Thus, in November 2008, Intel had just two groups of students in training, but they

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<sup>40</sup> As well as addressing the nursing market, Intel offers various other services in many subjects. The most widely advertised subjects are International English Language Testing System (IELTS), Test of English as Foreign Language (TOEFL), Scholastic Aptitude Test / Scholastic Assessment Test (SAT), Graduate Record Examination (GRE), Graduate Management Admission Test (GMAT), but Study Abroad is always on the top of the list in bold letters. It claims to have links with universities and colleges in many western countries.

<sup>41</sup> Intel brochure summer 2008, also see [www.intelinstitute.com](http://www.intelinstitute.com)

have a great many more during high season. The courses are taught by teaching staff from nursing colleges in Kathmandu. Other institutes offer the same services for potential nursing students. After the preparation, prospective students also have to pay for the initial application to sit the entrance exam: 400 Nepali rupees in 2006.

### *During training*

On average the total training cost in a private college is 3-4 lakh (approximately £2500-3500), excluding maintenance costs, for the three-year training period. There are additional fees for clinical placement facilities, costs which did not exist until the late 1990s, when private colleges started bringing nursing students into the few hospitals suitable for student placements. With the rapid expansion in private training colleges, placements became a scarce resource. Some hospitals then saw this as a way to generate income and introduced fees for all students from private institutions coming to learn clinical skills. Many students and teachers have complained, and media reports have highlighted that some hospital wards have more students than available patients' beds (Rai 2009).

Many hospitals are in this situation, but Thapatali Maternity Hospital is a useful example with which to illustrate this point. Thapatali Maternity Hospital is government-funded and the oldest maternity hospital in the country. Until the 1990s, students went there for Midwifery, Obstetrics and Gynaecology training.<sup>42</sup> Students at that time worked in a supernumerary capacity, as part of their training, free of extra costs. In the 2000s, the hospital board introduced a fee for all students who came there to learn and practise clinical skills. Now all categories of students in any aspect of healthcare training, be it antenatal care, intrapartum care, postnatal care or obstetrics and gynaecology have to pay 2500 rupees (approximately £20) for four weeks' placement. Every year several hundred nursing and midwifery students, ANM students, MBBS and other types of healthcare students go there for clinical placements. It has been a good source of income for the hospital. Other hospitals in the Kathmandu valley, such as the Army Hospital, the Police Hospital, Kanti Paediatric Hospital, Bhaktapur District Hospital, and numerous private hospitals also charge money for student placements. This fee, too, is borne by the students and their

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<sup>42</sup> I completed my midwifery, obstetrics and gynaecology clinical practice there during my staff nurse training in the mid 1980s.



parents. After completing the training, nurses try to gain some years of work experience in Nepal, as a part of their basic preparations for international migration.

### *The migration process*

Migration facilitation services are now available in Nepal. Nurses I have met in the UK who used one of the migration brokers have paid between £3000-7000 as their service fee. Brokering nurses is now a thriving business in Nepal and is fully discussed in Chapter Four.

Even after Nepali nurses reach the UK, they find that they need to provide further documents related to their initial training in Nepal, including evidence that they have had enough training to meet nursing professional standards in the UK. Nursing colleges charge a small fee for each single document and letter they issue for their graduates. Nurses have to cover all these costs personally. For example, a nurse who wants to come to the UK will begin the Nursing and Midwifery Council UK registration process. In order to make her application of intention to register with the NMC-UK, she requires various letters from her training college in Nepal. She will also need a letter from the Nepal Nursing Council, as evidence of her being a registered nurse in Nepal, and the NNC will also charge for this. Further documents (relating to her financial situation, English Language Test, and Police Report) all cost money. These requirements have created opportunities for new businesses in Nepal.

The fees nursing colleges charge their former students, for writing a training verification letter, merits closer scrutiny. Before 2000, Nepali nursing colleges hardly ever received such a request. From 2000, as the number of Nepali nurses trying to migrate to the USA and to the UK started to rise, the volume of qualification verification letters requested from foreign nursing and healthcare institutions rose. From 2002, Lalitpur Nursing Campus, Maharajgunj Nursing Campus and other institutes started using this opportunity as an income-generating source. As already noted, unless foreign nurse licensing authorities are satisfied with Nepali nurses' qualification verification letters, nurses cannot obtain their foreign nursing licences, so nurses are compelled to pay this fee.

These charges are relatively low and do not generate much income, but some new colleges seem to have been established purely as business ventures. The SAAN Institute of Health Science is one example. This institute was set up with an American link, not just to train nurses in Nepal, but to supply partially-qualified nurses to the USA and to facilitate nurse migration.

### *SAAN Institute of Health Science*

In 2005 SAAN grabbed headline news in the Nepali press and also became a subject of gossip amongst nurses in Nepal. The main criticism was that the institute was set up as a business venture (Pariyar 2005). When I started research field work in the summer of 2006, this was a 'hot topic' in Kathmandu. I learned that the Principal of SAAN was my former Campus Chief, Prof. Hari Badan Pradhan, a very senior professor in Nursing. I visited SAAN Institute of Health Science in Baluwatar Kathmandu, in October 2006 and met with her. We spent almost two hours there talking about the history of SAAN.

SAAN Institute started in 2002, with a view to offer young Nepali women an American nursing qualification, known as Associate Degree in Nursing (ADN), and help them migrate to the USA. The proprietor had conceived the idea of training nurses in Nepal for two semesters in-country, and taking partially-trained students to America to complete the rest of their training, thus giving them an ADN qualification, to equip them to work in the USA.

The proprietor, a non-resident Nepali (NRN) came to Nepal from the USA to set up this programme. He had appointed a NRN there to lead the team. He came to Nepal with the team leader and recruited a few Nepal-based teaching and management staff.

In Nepal they planned to recruit young women with at least 10+2 years of education and with a history of good academic achievement. They would study the first half of the ADN course in Nepal: two semesters of six months each. Then the students would go to the US and study for another year to obtain their ADN qualification. The training was American in style and the programme was affiliated with Eastern Kentucky University, I was informed.<sup>43</sup>

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<sup>43</sup> I tried internet search for this university and found no result. I am not sure if this university existed.

The programme began in Kathmandu with eighteen female students in 2004. The first group of students paid tuition fees of four Lakh Nepali rupees (approximately £3500-£4000) a year for the Nepal-based training. After the first two semesters in Nepal, only two out of eighteen students were granted US visas to continue their training there. The rest were very disappointed. These ADN students and their parents became very angry with the management. Quite understandably, students and parents started demanding their money back. This story became big news within the nursing profession.

These students and some of their parents contacted the NNC, the professional regulatory body, only to find that there was no record of any communication with the NNC regarding this training programme. The Nursing Council could therefore do nothing to help these students. The principal, who had come to Nepal to set up this programme, had a one-year contract. She completed her task, left the job and returned to the USA. By then it was late 2003 and the situation was chaotic. Students in Nepal had no idea what was happening with their training. The main proprietor of the college had to find some way out: either refund the students' money or do something about it. So he approached Professor Hari Badam Pradhan to help. At that time, Professor Pradhan was just about to retire from the TU, IOM. She accepted this offer from SAAN and started working there as the principal from 2005. She worked towards gaining affiliation with one of the privately-run Universities in Nepal, and towards getting NNC approval. She managed to get affiliation with Purwanchal University (PU) to run BSc. nurse training, with the aim of redesigning the whole programme to fit into Nepal's new BSc. nurse training. By then, Purwanchal University had new BSc. nursing programmes in the pipeline. SAAN became just one other BSc nursing programme to start that year. From summer 2005, the SAAN institute began its BSc. nursing programme. The first group of students previously enrolled on the American ADN course and who were unable to go to America, were placed directly into their second year of BSc. nurse training. She managed to recruit more teaching staff (as prescribed by the NNC) and started negotiating with a hospital in Kathmandu for clinical placements.

Initially the SAAN BSc. nursing programme had a contract with ManMohan Hospital for clinical placements. But in 2007, ManMohan Hospital unilaterally terminated the

contract to provide clinical placement for students from SAAN. I was told that this was because ManMohan hospital decided to start their own nursing training programme and could not accommodate students from any outside training programmes. Given the lack of a clinical training facilities, and pressure from the NNC, SAAN was compelled to stop taking new admissions in 2007. However, in 2008, SAAN managed to negotiate with another private hospital and could take new admissions again. Whether these graduates will be able to register with the NNC remains questionable. Certainly, as of 2008, the SAAN Institute programme was not accredited by the NNC.

### *Nobel Academy*

The Nobel Academy is another college running BSc. nurse training alongside its many higher education courses, ranging from business, accounting, arts, and management and engineering. It is almost like a higher education supermarket. The BSc. Nursing programme at the Nobel Academy began in 2006. After the first group of students was enrolled for training, the NNC published a notice in one of Nepal's national daily newspapers, alerting parents and prospective nursing students that the training run by Nobel had not been approved by the Council (NNC 2006). The refusal to accredit the training was because there was no associated hospital for clinical training. The NNC continued to put pressure on the Nobel College to find a suitable hospital in order to run its programme. Several months later, due to the lack of facilities in Kathmandu valley, Nobel College moved to Biratnagar, in east Nepal where a hospital called Nobel Hospital was under construction, established by the same company. In 2007 Nobel College tried to present this hospital as their main clinical area for training, and re-applied for NNC approval. The NNC had a second feasibility study conducted in 2008, but the hospital was still regarded as unsuitable and the application for accreditation was refused. Officially, the process of making new admissions was again suspended in 2008. The Nobel College did not formally advertise itself, but unofficially it was continuing to recruit new students. In September 2008, I had a phone conversation with the college receptionist and learned that they were taking new admissions for BSc. nurse training. The receptionist informed me that all administrative work was done in Kathmandu, but students had to go to Biratnagar for training, at least for the first two years. I tried to verify this

information with the NNC, but they had no idea what Nobel was doing at that time. With all these irregularities, it is not clear how Nobel College could have received its alleged affiliation with Pokhara University, another privately-run new university in Nepal. The hospital in Biratnagar was being built in late 2008, but the rumour was that the first group of BSc. nursing students was already in newly-located premises there.

SAAN and Nobel Academy are perhaps two extreme examples, but they reveal just how unregulated the private nurse training market is. Some others institutes are in similar positions. Yeti Health Science College, for example enrolled students in 2005-06, but later was compelled to stop the process of new admissions, because it had no hospital for clinical training. This was exposed by the national media, after much pressure from the NNC. It too moved to a different location and reopened the next year.

From the total of seventeen institutions running BSc. nurse training, only nine had full approval from the Nepal Nursing Council as of 13<sup>th</sup> May 2008. The remaining eight colleges did not meet even the basic minimum required standards set by the NNC. Nonetheless these un-registered programmes have been running since 2004-05. These cases provide some evidence about how economic interests are undermining professional standards: their quality, strength and integrity. Many side-businesses are springing up locally, but can be far-reaching international ones too. Some originated in Nepal and operate out of the country and others are moving into Nepal from outside. Some international nurse recruitment businesses link up with private hospitals in Kathmandu. They are discussed in the next chapter, given their close links with how nurses make migration decisions.

#### *Issues of professional regulation: Nursing Association of Nepal (NAN) and Nepal Nursing Council (NNC)*

The Nepal Nursing Council is a government body set up to maintain and regulate professional standards. I will examine the NNC's role in professional regulation, and what they are doing particularly with regards to the rapid increase in training colleges and their uncertain professional standards. NAN is a nurses' trade union body and has

also made a valuable contribution to professional nursing since its inception and also acted a regulatory body before the NNC was established.

The histories NNC and of NAN are very much interlinked. Available records show that the idea of establishing a nurses' association began at the same time as the start of the first NNC in 1958, with the help of two WHO nurses who started nurse training in Nepal. NAN (then TNAN) was an autonomous body, and was officially registered in 1962. In 1969 TNAN became an ICN member (Maxwell with Sinha 2004). NAN has remained continuously active since its founding. NAN has eleven board members and all are elected. It acted like the Nursing Council for many years. Before the NNC came into re-existence in 1996, NAN was involved in professional regulation and advocacy work, but NAN now has no authority to regulate and maintain professional standards. It has also been involved in various activities, such as organising nursing research conferences, workshops and political activism. There are no full-time members on the board and all the work is done voluntarily by members in their spare time. It remains, therefore, a professional body without any authority.

Alongside the early establishment of nurse training, the WHO nurses with their Nepali counterparts worked towards the establishment of a temporary Nursing Council in Nepal, housed under the Ministry of Health. This body, established in 1958, became responsible for awarding nurses' training certificates and maintaining professional standards and regulation. Initially, the Nepal Nursing Council did not accept nurses trained in Shanta Bhawan Hospital (SBH) School of Nursing, as it was established by a different group and there was very little professional communication. As a consequence, the 1962 and 1963 cohorts of SBH graduates were registered with the Bihar Nursing Council (India) as the main trainer at that time had a link with the Nursing Council there (Maxwell with Sinha 2004). In 1964, however, the SBH programme gained full recognition by the Council and the WHO, and the SBH adopted the curriculum designed for and used by the HMG School of Nursing. In 1972, when TU took responsibility for examination of both nurse training programmes, the Council was dismantled and there was no professional licensing and regulatory body until the mid 1990s (Maxwell with Sinha 2004; NAN 2002). In 1996, the Nepal Nursing Council Act was passed by parliament and the Nepal Nursing Council, a professional regulatory body was finally established. The NNC then started

keeping records of all professional nurses who were trained and practising in the country. Thereafter, by law, all nurses who wanted to work in Nepal had to be registered with the NNC.<sup>44</sup> The NNC has also been closely involved in establishing professional standards and regulations. In just a decade, the NNC has achieved a great deal, although much remains to be done in reaching internationally recognised professional standards and regulation, as I discuss below.

The NNC record for April 2008 shows that there were, in total, 10,017 qualified staff nurses registered with the NNC.<sup>45</sup> In addition, other categories of nurses were registered with the council: 11,097 Auxiliary Nurse Midwives (ANMs) and 529 “foreign-trained nurses” (NNC 2008).<sup>46</sup> By the end of the 2008-09 academic session, over 1,560 further staff nurses were expected to qualify (from the private and government sector combined). In addition I calculated that an additional 300 BSc. nurses would be trained each year by the end of 2009, based on 15 colleges training around 20 students in each cohort.<sup>47</sup>

### *Professional difficulties and political interference*

As a government body under the Ministry of Health and Population, many of the NNC’s board members are appointed by the Health Minister. Since its re-establishment in 1996, it has become totally politicised. Although its constitution states that the NNC is an apolitical body, many of its board members are changed every time the government changes in Nepal. When I visited the NNC in the summer of 2006, there was no NNC board in place. The former King Gyanendra’s Emergency government had just collapsed and the new government, led by the Nepali Congress Party, was still to appoint the new NNC board. Eight administrative staff were running the everyday business, but they received no salary for four months and were waiting for the government to appoint the new board, so that their pay cheques could

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<sup>44</sup> NNC Information booklet, 2053 (1997); NNC Act 2052 (1996).

<sup>45</sup> NNC registration is mandatory for nurses who want to register with foreign nursing councils now. Many foreign nursing councils require a professional verification letter from the NNC when Nepali nurses apply for foreign nursing licenses.

<sup>46</sup> NNC records were obtained on 13<sup>th</sup> May 2008 from the NNC website ([www.nnc.org.np](http://www.nnc.org.np)). In 2009, the NNC board changed and the website was being up-dated. It was still not available in July 2010, so I am unable to update this figure.

<sup>47</sup> In the academic year 2006-07 there were 15 institutions running BSc. nursing programme, with between 18 and 20 students in each group. This is a four-year training and the first group were expected to be ready by the end of 2009.

be signed. In such an environment, a professional organisation cannot be expected to maintain and regulate professional standards. A new board was appointed in the autumn 2006, but there was another change of government in the summer 2009, and the NNC board had been cancelled again and a new board was established.

The NNC also has responsibility without authority. One responsibility is to assess nursing training standards, but the NNC has no power to close institutes that fail to meet its standards. Additionally, the NNC has been regularly accused of being corrupt. Many private college staff informed me “one has to have *afno manchhe*, or the right connections, to get NNC approval to run a college”; that the NNC team conducting a feasibility study take bribes, and that the NNC has been heavily politicised (Rai 2009). I have frequently heard that the NNC receives regular phone calls from senior and powerful politicians, generally the ones who have shares in nurse training businesses, seeking their approval to set up new nursing colleges. I do not seek to accuse or expose any individual personally but want to highlight this aspect of the nurse training business in Nepal.

#### **D. Brief overview of the healthcare system in Nepal**

Having discussed the development and political economy of professional nurse education and issues of professional standard and regulation, I now explore what is on offer for new graduate nurses and the working environment they can expect within the Ministry of Health and Population (MoHP).

Before the advent of democracy in the 1950s, the modern biomedical system had very limited capacity in Nepal. There were only a few foreign trained private physicians for the Rana rulers and social elites. There were and are, however, multiple types of traditional healthcare practices working side-by-side. Ayurvedic medical practice, based on Hindu religious practice, has existed for centuries and is also officially recognised and available within the state-run health service. Other healthcare practices such as shamanic healing, homeopathy and herbal medicines are also widely available and have been practised for centuries by most people in Nepal (Dixit 2005; Harper 2003; Marasini 2003; Subedi 2003). It is not possible to chart all these different services and practices in this thesis. It is important however, to look at the



modern biomedical system because professional nursing is central in the modern healthcare service.

*Nepal's Health Service under the Ministry of Health and Population (MoHP)*

Since the establishment of the MoHP in 1954, it has remained the main player for the planning and delivery of state-funded healthcare services to the people of Nepal. In addition to employing various categories of healthcare workers, the MoHP has been involved in training health workers since its establishment. Although, it has been heavily supported by foreign aid, until 1972 the MoHP was the sole producer of healthcare workers in Nepal (apart from Lalitpur nursing campus which was then run by the UMN). After the establishment of the Institute of Medicine (IOM) under Tribhuvan University (TU), in 1972, all mid-level health workers' training responsibilities were transferred to the IOM. From 1972 till 1989 the MoHP was responsible mainly for the delivery health services, for the support of health workers in providing those services, and for in-service training to employees. In 1989 the Bir Hospital Nursing Campus was established and a few years later the National Academy of Medical Science was set up (directly under the MoHP) to train specialist medical doctors and nurses.

The Nursing Section was established along with the Ministry of Health, in 1954, to oversee nurses' professional issues such as continuing professional education, career progress and postings. The MoHP employs over 4000 nursing staff in positions ranging from ANM to Hospital Matron.<sup>48</sup> The MoHP also acts as a partner organisation to the Ministry of Education and Sport, and to universities and colleges for health workforce training, by providing training placements and cooperating in training planning, and policy-making.

There are 75 administrative districts in Nepal. According to National Health Policy, there should be one district hospital in each district. Because of geographical difficulties and poor transportation and communication networks, only 68 districts have government-run district hospitals (Marasini 2003). Some remote districts have small hospitals, run by charities and national or international-non-governmental

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<sup>48</sup> Interview with Dr Marasini, Human Resources Department in the MoHP, Kathmandu, on 23<sup>rd</sup> of November 2008.

organisations (NGOs/ INGOs), and some districts have no hospital at all. District hospitals each have at least fifteen inpatient beds and normally two or three staff nurses supported by two ANMs. One step up from the district hospital are the zonal hospitals, in most administrative zones, with more inpatient beds and other hospital facilities, and more doctor and nurse positions. Above the zonal hospital are regional hospitals, one in each of the five development regions, acting as tertiary care referral centres. There are also some government-run specialist hospitals such as the Paediatric Hospital, the Cancer Hospital, the Heart Hospital, the Eye Hospital, the Maternity Hospital, and the Infectious Diseases Hospital. All are in the Kathmandu valley (Marasini 2003).

The concept of Public Health was introduced in the 1960s. The main public health programmes (such as immunization, nutrition, health education, family planning, malaria eradication, water and sanitation) are heavily supported by NGOs/INGOs. There are Public Health Nurse positions in each district and Auxiliary Nurse Midwife positions in health centres and health posts across the country, mainly for the delivery of preventative services. Nurses play key roles in all of these service above, but I focus here on the situation of professional working, within the MoHP, in Nepal.

#### *Nursing and the professional working situation within the MoHP*

As a part of the restructuring of the national health system in 1993, the nursing section was dissolved. Government policy was to decentralise the healthcare service delivery, training and management to regional level. Since then, there has been no full-time and regular nurses' representation at policy level at the Ministry of Health. Nurses working within the national government system say that they have no clear communication channels and mechanisms for contacting people to make complaints, or gain support and advice, when facing professional difficulties. This seems to have created a chaotic working environment.

As a result of this, the NAN and the NNC, with support from experienced nurses, have been campaigning for the reinstatement of the Nursing Division. During the research field-work, I met many nurses working under the Ministry, who spoke at length of low morale and chronic dissatisfaction. They had many pressing

professional issues, including the lack of professional representation at health-policy level in the ministry. A senior nurse at the Nursing Focal Point at the MoHP told me.

If you are making any policy recommendation or any suggestion [from this research] to the MoHP, please tell them that we want our Nursing Division back. Doctors have their own Medical Division which deals with their professional issues, but there is no responsible section in the MoHP for nurses. Who is going to do anything for nurses? We feel demoralised; there is no senior policy level position for us. There is no hope for our future and job promotion.<sup>49</sup>

This nurse blamed the previous Chief Nursing Officer (CNO) for the collapse of this post. She further said “when the old CNO retired she cancelled this position, she said nurses do not need to be at that level. It is because she did not want anybody else reach to that level”. But later in autumn 2007, I met this retired CNO and I asked her for her opinion on this issue. She said “it is not because the position is cancelled but there is no nurse in the country who meets all the required criteria to get to this position”.<sup>50</sup>

Decentralisation seemed progressive at the time but, because of the unstable political situation in the country, this has not yet happened as intended and, as of autumn 2008, there was no clear line management. Nepal’s health service policy has been completely centralised: staffing and vacancies for permanent positions are decided at central level. Dr Marasini, who was Human Resources Co-ordinator within the MoHP, in the autumn of 2008, commented:

There is no clear policy on health service administration, so these are constantly manipulated/ interpreted by individuals at policy level. Because of a lack of clear policy and bureaucratic incompetence, some key nursing positions have been vacant for a long time.<sup>51</sup>

Whatever reasons are behind this situation, many nurses want to have the Nursing Division back. I met nurses working in the Western Regional Hospital in Pokhara, and in government hospitals in Kathmandu, who all agreed that the line of nursing management within the MoHP is not clear. Nurses expressed concerns about retirement and pensions, and professional development. They felt that there needs to

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<sup>49</sup> Interview with a senior nurse level 10, in the MoHP October 2007. This nurse took early retirement in the summer of 2009. When I went back to Nepal in autumn 2009, nobody was available at the nursing focal point in the MoHP

<sup>50</sup> Interview with the retired CNO, Autumn 2007, Kathmandu.

<sup>51</sup> Interview with Dr Marasini, Human Resources Department in the MoHP, Kathmandu on 23<sup>rd</sup> of November 2008.

be strong nurse leadership to take nurses' issues to the policy level. The government considers that anybody capable of doing this job, from any discipline, is eligible for this position. Dr Marasini stated:

...there is a leadership lacking in nursing, there is no nurse qualified to take this responsibility.

He criticised the dual management system in all public sector departments in Nepal, with staff in the health sector, managed by both the Ministry of Health and the Ministry of General Administration. As a consequence there are numerous loopholes and weaknesses. My next question to him was about the recruitment and retention of nurses in the government sector. He responded:

There are numerous bureaucratic hurdles to go through here. After we cross all the bureaucratic hurdles of advertising to fill the vacant positions, we presently do not at least, have a recruitment problem. We do receive plenty of good candidates and we can recruit the number we need. But there is a problem with deployment. The majority of nurses with good academic records, who are from the better institutions like Maharajgunj and Bir Hospital Nursing Campuses always come ahead in the selection process. But, they want to stay in the Kathmandu valley. This way, they don't just have a secured government job in the valley but they also have many other part-time extra work opportunities and opportunities for professional studies. They do not want to go out to the district. After they get a government job offer, they start using their political connections and *afno manche* (one's own people) network to find them a place in Kathmandu. Many end up in the valley; but for those without an *afno manche* connection and coming from the rural districts they don't even get any job. There is no mechanism within the government to deal with this situation. These nurses get their *kaj* (secondment) arranged. We cannot fire them and cannot recruit somebody else. So on paper, it looks like nurse A is in the district hospital, but physically she is in the Kathmandu valley.

Lack of supervision, work evaluation, incentive rewards and incentive and promotion opportunities are further key factors. A senior nurse in post in the Focal Point for Nurses in the MoHP said:

I act as a contact person [at the focal point] for all the nurses who work in the Ministry of Health in Nepal but there is nobody responsible for any performance evaluation of nurses in the country, at least within the government system. There is no praise or incentive for good work nor any caution for poor performance. So, we nurses feel demoralised and we are here without any authority. I am here as contact person but I have no authority for anything else.<sup>52</sup>

These examples illustrate how newly qualified nurses are interested in government positions, but prefer to live and work in the Kathmandu valley and then seek other

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<sup>52</sup> interview with Nursing officer in MoH in autumn 2007

opportunities locally. Those in the district hospitals are left without any support from the centre. Further, because of bureaucratic problems, there is no efficient and clear mechanism to recruit staff and fill vacancies. In summary, there is generally little attraction in working outside Kathmandu, mainly due to the poor salary, a lack of incentives reward system, and no proper job evaluation. Promotion possibilities are poor, if one does not have *afno manchhe* at the policy level.

The shortage of staff for all categories of health workers, including nurses, in rural hospitals is a major and a chronic problem in Nepal. The nurse I interviewed in the MoHP in 2007, said “our record here shows that over 90% nursing positions in the government sector are filled”, but it does not mean that nurses are physically present at their designated posts. Dr Marasini gave a more realistic view: “there are less than 50% Staff Nurses’ present at the district level, and there is an oversupply of nurses in Kathmandu while some district hospitals have no staff nurse in place”.<sup>53</sup>

The MoHP Policy on human resources and nurses’ training seems almost non-existent. When I asked Dr Marasani about the new four year BSc. Nursing programme and the future of the graduates, he said that the MoHP has no idea. Private colleges had not consulted the MoHP about whether any future posts would be available for the graduates he commented, and those colleges would have to deal with this new problem. His policy analysis clearly states “there is no coordination mechanism present between the Planning Unit, Production Unit and Management Unit on Human resources for health planning, production and management of human resources for health” (Marasini 2003).

A further important factor is the structural adjustment policy (SAP) adopted in 1985, and the process of market liberalisation that started from the late 1980s (Rankin 2004). Consequent to this, the private sector has gradually become one of the main players in health service delivery. This has undermined the service delivered by the public sector. As well various kinds of training institutions, there are now more hospitals and nursing-homes run by the private sector than by the government. Most of the essential health services are provided in the private-for-profit facilities. Dr. Marasini suspects that the private sector employs, by the late 2000s, almost 40% of all

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<sup>53</sup> Interview with Dr. Marasini, MoHP, Kathmandu, on 23<sup>rd</sup> November 2008.

health workers in the country. In addition, the private nursing-homes and hospitals I visited in Kathmandu, all had very quick staff turnovers. There is no long term planning to retain nurses in the private sector. It seems to be a “patch-work” style of management, and the government has no control over this.

## **Conclusion:**

This chapter has traced the history of the nursing profession in Nepal. No nursing education was available in Nepal before the 1950s. When modern education programmes started in 1956, it was hard to find suitable nurse candidates. It took over 30 years to establish the profession. Since the 1990s, it has grown rapidly, but mainly in the private sector. Many senior nurses described the rapid increase in the number of colleges as ‘mushrooming’. They attributed this, first to the growing demand for more training places and, secondly to the privatisation in technical and professional education and lack of government control and monitoring. As the political situation remains volatile, all stakeholders such as CTEVT, TU and MoHP face many difficulties. The MoHP has problems with staff deployment in rural areas. Private sector stakeholders are exploiting the weakening government capacity in relation to professional regulation and control. This issue has been regularly exposed by the Nepali media (Rai 2009; Pariyar 2005). The NNC should be holding the reins to regulate and maintain professional standards but, however hard it tries, it still remains ineffective. Economic interest has been a major force undermining professional interest.

Social changes (outlined in Chapter Two) and professional changes (discussed in this chapter) have both encouraged and facilitated Nepali nurses to go abroad. The new generation of nurses seem to want to work in Nepal for only a few years after graduation, long enough only to gain the most essential clinical experience, before they head abroad. How nurses prepare for their move, what factors and forces play vital roles in the nurse migration process, are explored in the next chapter.



**Figure 4.1: Putali Sadak, Kathmandu: A bustling road with many billboards of International Educational Consultancies (IECs), in the summer of 2008, photo by Radha Adhikari).**



**Figure 4.2: IEC billboards in Bag Bazar, Kathmandu, Summer 2007, photo by Radha Adhikari)**

## **CHAPTER FOUR**

### **INTERNATIONAL MIGRATION: PLANNING AND PREPARATION**

Chapter Two revealed that opportunities for Nepali nurses in western countries are considered by far the most desirable career options by many new generation nurses and their families. A nurse migration journey however is not a simple one. It requires a large amount of money and access to information about the possibilities of the move and future work.

When the British healthcare system experienced a severe shortage of trained nurses in early 2000, some of the NHS trusts resorted to international recruitment as a short-term measure. This news circulated the globe and very quickly it reached Kathmandu too through Nepali Diaspora networks. A few nurses came to work in the UK first. Their friends and colleagues left behind then showed interest to come to Britain too. Within a few years it became the most popular career move, and many nurses started looking for any possible route to work in the UK. Nurse brokering agencies sprung up and they started facilitating the nurse migration process. As well as the UK, these migration brokering agencies in Nepal gradually started exploring wider international destinations such as the US, Australia and New Zealand. Agencies are commonly known as International Education Consultancies (IECs).

In 2007-08 there were over one thousand IECs in Kathmandu, although the exact number directly involved in brokering nurse migration is not known. Most IECs provide information on various possible destination countries; country-specific immigration policies; the types of visa a qualified nurse can obtain; job possibilities for nurses once they reach their destination and the estimated costs of migration. This information plays a vital role in the whole decision-making process. In this chapter I examine the role of IECs in nurse migration from Nepal, but begin by looking at why the nurses I interviewed thought migration to the UK was the most desirable move for them and how they tackled all the necessary steps and processes. Here I look at how nurses make migration decisions; choose the UK as their destination and obtain entry visas to move to the UK; and at how they negotiate the practical hurdles in the migration preparation process.



Kingma (2006) discusses three main steps in preparing for migration, namely getting qualifications, obtaining a license to practise (both nationally and internationally), and obtaining visas and work permits. For Nepali nurses steps two and three are not so linear and straightforward. After qualifying, nurses are registered with the Nepal Nursing Council (NNC) and obtain a licence to practise in the country. However an international nursing licence, particularly a British one, cannot be obtained from Nepal. This is one of the most difficult challenges for the majority of nurses trained in countries outside the European Union (EU), who try to register with the Nursing Midwifery Council (NMC) in the UK.

### **A. Reasons for migration**

There are various commonly discussed reasons for human migration: principally for economic gain; then for career moves; for family reunion; due to war and for personal safety, amongst others. The majority of Nepali nurses seem to have moved for a better quality of life for themselves and their family, and for better professional opportunities in the UK. Kingma explains “economic migrants are attracted by a better standard of living or by the possibility that they can provide an additional income for family members” (2006:15). This is important in the Nepali context: educated and skilled professionals’ migration to developed countries is widely perceived as a betterment of their living standards and that is a sign of success for the family as well as career success for the migrants themselves. International migration of a family member is about pride, linked to the desire to be modern and successful.

Kiran came to the UK in July 2005 to work as a nurse. She is a daughter of an ex-Gurkha soldier. She lived in Hong Kong when she was young but later went back to Kathmandu for her secondary school education. She completed her schooling and entered nurse training in one of the TU-run programmes in Kathmandu. She told me that she wanted to be like the nurses who worked for the Gurkhas’ families in Hong Kong, and that she was very impressed with the profession and the possibility of working in other countries outside Nepal. After she completed her nurse training, she worked in Patan Hospital, run by the United Mission to Nepal and then, three years later, she completed a two-year Bachelor degree in Hospital Nursing (BN) from the college where she did her initial staff nurse training. After completing her degree, she

was employed running a clinic for Gurkha families in Kathmandu. When I met her in Hastings, she told me her personal story this way:<sup>54</sup>

I got married during the training, it was an arranged marriage. My husband also comes from a Gurkha family, so we were brought up in very similar circumstances. Our parents arranged it. A few years later we had a daughter. We were all in Kathmandu, living happily. In summer 2004 we [her husband, daughter, and herself] went to Hong Kong for a short holiday. We were away for three weeks only. When I came back one of my close friends was ready to leave for the UK. It seemed all so quick. Even my close friend was so secretive, did not want to tell me anything until she got her British visa stamp, and I was so surprised to hear this news. Later that year, many nurses I trained with started leaving their jobs and moving to the UK, some to the USA or Australia. After that I felt like finding out what was in those countries. So I spoke with my husband. He agreed with the idea that I should find out more about it. Then I went to see Mr. Jordan, who was running the UK/US Educational Council in Naya Baneshower, Kathmandu. He gave me some ideas and information on possible ways to come to the UK. I started the process and he helped me to get a National Vocational Qualification (NVQ) student visa. I paid four Lakh Nepali rupees [roughly £3500] for his services, I had my visa granted, and I came here [to Hastings] leaving all my family behind.

She also reflected on her last job in Nepal:

It was a fantastic job. There were over two hundred applicants for one post and I got it. I was very happy; all my family lived nearby in Kathmandu.

After she arrived in the UK, she joined an adaptation training programme, through which she received NMC registration and her Professional Identification Number (PIN). After many applications and disappointments, she secured a permanent post in a nursing-home in Hastings. With the job, she received a five-year work permit. She started working and managed to save enough money. With some help from her family in Nepal, she invited her husband and eight-year-old daughter to join her as dependant family members. When I met her, she was working in a nursing-home and living with her husband and daughter.

*Migration: a sign of career success and family success:*

When I asked nurses what their personal and family expectations were from this move, the reasons were different, depending on at what stage the nurses were at the time of interview. Nurses in Nepal, who were still hoping and preparing to migrate, said that it is for better money, higher living standards, for their family's future and an easy life. But those already in the UK who had had a taste of British living standards

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<sup>54</sup> Interview on 10<sup>th</sup> February 2008, in Hastings, England.

and working environment expressed this differently, some in a regretful way. One nurse, who, at the time of the interview lived in rural Oxfordshire with her husband and two children and had a full-time job in a private nursing-home, said;

...it was all that *hawa* and *hallai halla* (wind and noise, or whim). After completing my BN degree course, I was teaching in Om Nursing Home. While working there I saw so many people trying to go abroad. I was heavily influenced by my professional colleagues and friends as so many of them were preparing to go abroad. ***I felt that I had to do something, to be successful in my professional career*** [she stressed].<sup>55</sup>

Another nurse, Sarita had worked in Tribhuvan University Teaching Hospital (TUTH) for over twelve years. She had a Bachelor's degree in Hospital Nursing, in Nepal and, at the time of the interview, worked in England. She described how she too was influenced by her friends:

When I completed my Bachelor's Degree in Hospital Nursing, I went back to the TUTH. I started working in ICU, I felt that I had achieved my goal, completed my further education and it was time to settle down in a job, and relax. The culture there was so different from two years ago, when I left TUTH for further study. Now, so many are trying to go to America or UK or Australia. So many nurses were leaving the teaching hospital (TUTH) every month for overseas jobs. My friends and colleagues started asking me why I was not interested in migrating and not doing anything about it, not making any move. I tried to ignore this for a while, but the cultural pressure managed to change my *psychology*, I felt that maybe ***I was not doing anything, so I am a failure***, as I was not taking any interest in going abroad. A few of my nurse friends were already here in the UK. Some in Kathmandu were preparing to leave. So I had to do something too. I started the process, and here I am now.<sup>56</sup>

Sarita too felt she had to 'do something'. She did not want to be a failure, so joined an increasing number of migrants leaving TUTH and many other hospitals in Nepal. Another nurse blamed this new migration culture for its encouraging of people to want to go to western countries. In almost all informal talks about the migration motivation for Nepali nurses in general, nurses talked about the *hawa* (wind) and *halla* of (noise, rumour) in Kathmandu in young professional circles, and of the fabled possibilities for nurses to go to this, as yet, unseen world. The world out there appeared better than the world they lived in. These *hawa* and *halla* influences inspired many to migrate, and an increasing number of nurses felt compelled to go and experience the western world, in order to be seen as successful in modern society. As Kiran stated:

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<sup>55</sup> Interviewed on 27<sup>th</sup> of February 2007 in rural Oxfordshire, England.

<sup>56</sup> Interviewed on 28<sup>th</sup> of February 2008 in rural Buckinghamshire.

We are living in a culture that now everybody wants to go abroad [she raises her voice]. This desire to go to a foreign country is so strong that we selectively do not want to hear anything negative about the possible job abroad. It seems nurses are just ready to leave the country under any circumstance. Once you have a visa and have bought a ticket, it feels like this is the time of success. I had a good job, a fantastic job, there were over 200 candidates to get one job, with a British-style management and relatively well-paid and respectable post, and it was not enough for me. When I saw some of my close friends leaving the country and coming to the UK, I felt that I had to do this too... all the family were very supportive as they all knew that it was a sign of personal progress. Getting the visa stamped was a sign of success for me and here I am now.<sup>57</sup>

In the summer of 2007, I had an opportunity to meet a group of 20 students studying for a BSc. nursing in one of the TU-run colleges in Kathmandu. Many said that the reason for taking this career path was to be able to go abroad. But why and what is out there, I asked? The common reason expressed by the students was for further study and *to become a successful person*. All seemed to have high hopes of becoming a successful person by going abroad for better education and combining this with a job so that they could support their families.

The potential for success is not just a matter of the nurse's own pride but migration is also something of which her family can be proud. My impression is that to be a success means achieving educational ambitions and earning more money, which raises family social status. There is therefore a strong family interest in young educated professionals contemplating an international career move.

#### *Family and social support as well as pressure*

One of the main arguments in this chapter is that migration decisions are not just individual nurses' decisions but also collective ones. As Kiran's story shows, making migration decisions is a family matter, and many Nepali nurses I interviewed pointed out that it requires family support and effort. Thus, making migration decisions cannot be discussed without understanding nurses' family dynamics, and this is particularly important in the South Asian cultural context (Thapan 2005). Nurses' families are actively involved in all aspects of the process, from choosing nursing as a career to making the international move.

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<sup>57</sup> Interview on 10<sup>th</sup> February 2008, in Hastings, England.

First and foremost, nurses need financial support all the way through, from their initial nurse training to arrival in the UK and settling-in here. International migrants are usually not the poorest people in their society. They need a considerable amount of money to make their journey possible. Not only is nurse training becoming expensive, but most of the nurses I met had paid a sizeable service fee to an agent for facilitation services. Nurses who have young children, usually have family in Nepal who will look after them there, at least for a couple of years until they settle in their chosen country and are ready to invite their family to live with them. This has also been the case for many migrant nurses from Kerala India (Percot 2006; George 2000), Bangladesh (Rozario 2005), and is common practice amongst Filipino and Caribbean nurses (Connell 2008).

One nurse living in a small town in Scotland shared her experience. Her story was fairly typical amongst Nepali nurses, and illustrates how much family support nurses are given at every stage in their lives:

My *daju* (elder brother) was very supportive and keen for me to go into nursing... He did all the initial training applications [enrolment] for me while I was still in the district with my parents, and he supported me to come to Britain too. All my family are very supportive, now when I am free on my day off we come on-line together and we chat for hours. This is how I spend my time off.<sup>58</sup>

Another nurse's story shows how far a family can influence a young woman in making her career choice and migration decisions. Jaya is a newly-qualified young nurse, from a middle-class family with little experience of living on her own. Both of her parents were teachers who owned and ran an English-medium private school. There were plenty of people to do all the domestic work, washing, cleaning and cooking and she did not have to do any chores herself. Later, when she became a student nurse, she lived in student accommodation with full facilities: food, lodging and transportation. There too, she did not have to do any domestic chores. After she qualified, she worked in a hospital in Kathmandu and lived as a guest with family friends. She was very comfortable there, and was not sure she really wanted to come to the UK. She found it difficult to make up her mind, and was unsure about her ability to migrate abroad and manage independently, without any support as regards everyday domestic work. Her father, a somewhat overbearing and dominant

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<sup>58</sup> Interviewed on 21<sup>st</sup> of June 2007 in Dundee, Scotland.

personality, was very keen to send her abroad; he almost pushed her to find out about job opportunities in the UK. He himself went to see an agent and paid the fee for the service and he also started the visa process for her. She says that she had to agree with her father, as his desire to send her abroad seemed so strong, and he started manipulating her emotionally, saying that she was the first child in the family and had to be in the right path to be able to help and guide her younger siblings. She felt that she just had to do whatever her father wanted and eventually the pressure was so great that she agreed with him. For her, the migration decision was more about her father's desire than her own to travel outside of Nepal. For Jaya, migration was necessary to maintain her father's and the family's *ijjet* (pride, honour).<sup>59</sup>

Lila, another more senior and experienced nurse I met in Scotland told me that she decided to migrate because of her family circumstances. She stated:

I had a job and was earning quite well but my husband was not earning much. We have three children and they were all in private schools. It was getting difficult to cover all the expenses even with a bit of extra money from some short-term consultancy work. As the desire to live in modern luxury increased for everybody in the family, my husband started suggesting that I look for international jobs. This way we can afford to enjoy our rising living standard. So I felt that I was not just supported to migrate but pushed to migrate by my own husband, so he could come here too as a dependant partner.<sup>60</sup>

For many families, only nurses can open the door to opportunities to migrate, then a nurse's immediate family can join her later. Nurses and their families are fully aware of this possibility.

### *Women's agency*

When it came to making migration decision, "influence" is the most frequently used word by the nurses.<sup>61</sup> As highlighted in Chapter Two, young women in Nepal are not used to making major life-changing decisions by themselves. It can invite social criticism of women being strong-willed, and not brought-up properly. Because of this background, perhaps nurses did not want to be seen as breaking socio-cultural norms by making major decisions themselves about such issues such as international migration.

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<sup>59</sup> Issue of *ijjet*, has been discussed in Chapter Two and is discussed further in Chapter Seven.

<sup>60</sup> Interviewed on 19<sup>th</sup> of January 2008 in Aberdeen.

<sup>61</sup> Nurses used the English word 'influence'.

After the first few interviews, it became apparent that nurses felt it more relevant to talk about what the “influences” were that led them to migrate, rather than their “motivations”. Nurses seemed to feel more comfortable and find more relevance in using the word *influence*, as broader social processes and relations (everyday social and work interactions with professional colleagues, friends and families) had influenced them to make decisions, rather than any individual desire. The most common source of influence for nurses was stated as their friends. Peer and social pressure featured highly: “it is our society in Nepal; one has to migrate to be successful in one’s career and as a sign of progress”. It becomes a common source of pressure: the idea that nurses have so many international opportunities, and if they do not grab them, there must be something wrong with them. This was the impression I gained when I interviewed these women.

The experiences and stories of the twenty one nurses I interviewed, and the countless conversations and social contacts I have had with nurses in Nepal, and in Britain, are varied. One element, common to most, is that migration is about fulfilling their own or their families’ material desires, and about uplifting their social status and *ijjet*. All of them said that they had full family support in making decisions to migrate to the UK. Family, friends and even extended relatives agreed to lend some money to cover their initial expenses. It seems like a kind of collective family investment. None of the nurses I interviewed said they felt any resistance to, or restriction on, their migration, in fact quite the opposite. As some of the extracts from my interviews suggest, migration to Europe, America and Australia is seen as real progress and success in their lives, which can be shared later by family and relatives. As Liechty suggests, having friends or relatives living in the UK provides a window into another cultural world (Liechty 2003. 51), and looking for international opportunities is a “must-do thing”, a sign of being *modern* and *successful*, in contemporary Nepali society. There is a new emerging economy that supports this modern aspiration.

#### *Nurse migration market economy*

Considering international migration, and choosing the UK as the destination and a route to get there, very much depends on what information is available in Nepal. As nurses mentioned to me, *hawa* and *halla* (rumour), and “influences” are always there in the background, and also play vital roles when making these decisions. In July

2007, NORVIC Technologies in Kathmandu, in partnership with a UK-based international health workers' recruitment agency called Healthcare Locum (HCL), made an agreement to set up an American Nursing Licensing Exam (NCLEX) centre in Kathmandu. This was reported by the Himal News Service (2007), which said;

...During the MoU-signing ceremony, HCL managing director Mick Whitley said the World Health Organisation has stated that there are 4.1 million clinical vacancies worldwide, with over 700,000 vacancies in North America alone.

"There is an opportunity for Nepali nurses to work in the US and enhance their skills on par with the nurses of America."

The initial process includes: identification of the nurses; mini-NCLEX examination; HCL International Clinical interview; HR interview; desire to relocate in USA and initial immigration assessment. After the candidates pass the process, they will receive full training in the NCLEX, said Whitley. "The nurses would receive the same salary the nurses in the US are drawing," Whitley added.

At a time when the majority of Nepali nurses are facing problems to secure jobs in foreign countries, the agreement would make them easier to be hired in the US, Dr Mahabir Krishna Malla, director of the Norvic hospital, said.

He said the examination centre would be set up by next year. Some 25 nurses would be trained for the global recruitment this year and the number would increase yearly, he added.

Nurses hear about migration opportunities not just from their friends or relatives, but through messages and images of nursing opportunities in the west circulating throughout the country. These advertisements are there for everybody to see, and the internet is widely used as Nepali citizens surf the net in search of opportunities. They are further influenced by active and aggressive marketing by migration brokers. At the time of the research of summer 2006-07, there were over a thousand educational consultancies operating in Kathmandu and in the bigger cities. As their registration with any government department is not compulsory, the exact number is not known. Several have good international links: some specialise in migration to the UK, some to Australia and some to the USA. The market is there to cater for modern desires and aspirations, and these brokers understand and manipulate it. Through this type of recruitment the market feeds off and further fuels the nurses, and their family's desires to migrate.



*International Educational Consultancies (IECs)*<sup>62</sup>

One of the Kathmandu-based computer institutes called ‘Diana Computer Institute’ offers diverse services from computer training to language training, visa interview training and other help for young Nepalis keen to migrate. The manager said:

Nurses have very good scope abroad. They get good nursing jobs in a good working environment, good salary and prestige. But people don’t respect the nursing profession in Nepal. In the UK, the average annual salary of a single Matron is up to £75,000.00. Until about six years ago nurses did not have to pay consultancy fee to go to the UK, all used to be free of cost. But, nowadays one Educational Consultancy named Versatile gets 6 to 8.50 lakh (approx £5000-7500) as a service charge. If the visa application is rejected, they give all refund everything except 2500 Nepali rupees (approx £20).<sup>63</sup>

This market is by no means exclusively for nurses, but also for other young Nepalis who want to consider international opportunities to study and work abroad. In order to cater for a wider group of people, the majority of migration brokers in Kathmandu have various tailor-made advertisements to suit various courses, costs and destinations. It would be quite possible to have several members of a family trying for different opportunities in different countries at the same time. But currently many people believe the nursing profession provides more international opportunities than any other profession.

A nurse who used one of the IECs in Kathmandu to come to the UK told me that she was told by the agent:

You go ahead, you go ahead, and there are a lot of opportunities waiting for you.

These migration brokers in Kathmandu also offer ‘Study Abroad’ programmes and are well-linked internationally. Their main sales pitch is that ‘Study Abroad’ is a first step for Permanent Residency (PR) status in wealthy western countries. Next, I wish to focus on and discuss these IECs and how the ‘Study Abroad’ market is operated in Kathmandu. I analyse their advertisements and the way they give the impression that their programmes will help nurses’ migration dreams come true.

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<sup>62</sup> A discussion on International Educational Consultancies and brokering nurse migration has been published in *European Bulletin of Himalayan Research*, 35-36 January 2010. Please see appendix for the final version of this publication.

<sup>63</sup> Interviewed on 17<sup>th</sup> July 2007, Kathmandu.

There are over 1,000 International Educational Consultancies in Nepal. As well as providing entrance-exam preparation courses to pre-nurse training students (as discussed in Chapter Three), they assist qualified nurses in making international moves. These consultancies are for profit, and usually run as business ventures. The majority of them are based in Kathmandu, with branch offices in bigger towns like Biratnagar, Dharan, Birjunj, Pokhara, Butwal and Chitwan. There are some small local educational consultancies, targeting the local nursing market at the district level, usually where nurse training institutes are located. These consultancies offer a variety of services in many areas and in almost any subject one wants; the most widely advertised areas are IELTS (international English language testing system, run by the British Council), TOEFL (Test of English as a Foreign Language, required for further study in the US), SAT (Scholastic Assessment Test), GRE (Graduate Record examination, required for a further study in the US), GMAT (Graduate Management Admission Test), but ‘Study Abroad’ is always on the top of the list in bold writing.

Bag Bazar, Putali Sadak, Naya Baneshowar, and Patan are the main ‘hot spots’ for ‘Study Abroad’ education business. I visited Bag Bazar several times. This is a busy road in the centre of Kathmandu. One cannot fail to notice the sheer number of their advertisements. I counted all bill boards related to educational business there, and there were over one hundred advertisements for International Educational Consultancy services, in a road which is only about 400-500 metres long. Their advertisements and bill boards are placed in hundreds of other places: like hospital gates, nursing college and university gates and road junctions. They are further advertised in national newspapers. Below are just a few samples of these.

On 13<sup>th</sup> of October 2008, in the classified section of the *Himalayan Times*, there were many advertisements on the international availability of many courses and how they can be sourced via one of these educational consultants. In this section, Interface Education Centre Pvt, Ltd, reads ‘Study in Australia’: M Vision Educational Consultancies reads, ‘Study in Australia, up to 40% scholarship available (scholarship that covers 40% of course fees)’; ‘Study in Cyprus’ is offered by GEMCP Ltd.; Friends in Collaboration Consult Ltd reads ‘Study and Work in USA, Europe, UK and Canada’; while President Educational Consultancy says, ‘Study in Europe; the country and courses of your choice’, etc. At least ten further IECs advertised their

services and many of them offered very similar services. There are other major national daily newspapers. *Kantipur*, *Kathmandu Post*, and *the Rising Nepal* and all have large sections of study abroad advertisements. I visited a few high profile ones, those most talked about by nurses, and ones which specialised in nurse migration in Kathmandu. They were the Versatile Education Centre, The Real Dream Educational Consultancy, and UK/US Council.

*The Versatile Education Centre, Putali Sadak, Kathmandu*

On the 9<sup>th</sup> of October 2008 in the *Kantipur*, the Versatile Education Centre advertised “Free counselling and on the spot admission” and again the next day on the 10<sup>th</sup> of October 2008, it advertised a wide range of subjects available in the Thames College in London. The advertisement further read:

*Do you want to make your guardians free from the financial burden of your education? If your answer is yes, join London Thames College, we guarantee paid placement on selected courses.*

“National Vocational Qualification” (NVQ), “Health and Social Care” and “Dental Nursing” head the list of courses offered at the college. On the same page there were many other similar adverts: AlfaBeta Institute Private Limited presents “3<sup>rd</sup> Grand World Education Exhibition 2008, says free entry, and programmes are planned in, Chitwan, Butwal, Pokhara and Itahari and counselling destinations for USA, Australia, UK, Canada, Ireland the Netherlands, Norway, etc”. The list goes on and on.

The Versatile Education Centre has been one of the three major IECs to have successfully brokered Nepali nurses to the UK. I went there to follow up the advert above and to find out how they organise and manage these courses. When I arrived at the office in Putalisadak, the course co-ordinator, Mr Sharma, from the London Thames College was sitting in his office-consulting room. As there was nobody waiting to see him, I was able to see him straight away. He informed me that they offer many courses in London and was happy to tell me about the Health and Social Care related one, as it is close to nursing. If a Nepali trained nurse has at least a year’s work experience in Nepal after her training, and has an IELTS score of 7, they can facilitate the process of her applying to the ONP (Overseas Nurses Programme) in the

UK. This gives the nurse an opportunity to work in the clinical nursing field. But, in his experience, nurses are finding it increasingly hard to obtain an IELTS score of 7 so they do not progress beyond this point and therefore have no chance of becoming a nurse in the UK. An alternative route is to enter the UK as an NVQ (National Vocational Qualification) student. This route will be discussed in Chapter Five. The IELTS requirement for NVQ courses is only 5.5, but 6 is better, he added. Mr Sharma said that he was responsible for all South Asian countries. He claimed that the Versatile Education Centre had been sending nurses to the UK since 2003 and had sent about 300 Nepali nurses to the UK for the ONP and the adaptation course and around 70-80 for NVQ training and that they had had no visa refusals for nurses.

Mr Sharma further explained that Health and Social Care is about the management of healthcare, not about clinical nursing. It is better for a trained nurse to go for an ONP. If they cannot get an IELTS score of 7, they can certainly enrol in NVQ training, and in this case their appropriate NVQ level would be at least 3 or maybe even 4. London Thames College runs an ONP every three months, but the number of Nepali nurses doing this has decreased significantly since the NMC changed their policy on the language test. In October 2008, there were between 2 to 3 Nepali nurses enrolled in the ONP, but the college in London had at least 25 to 30 students in each group. The majority of these were from the Philippines, India, and Sri Lanka, as their standard of English is better than that of Nepali nurses.

A consultant from London Thames College visits Kathmandu for an educational fair and to provide consultancy services every three to six months. All candidates' educational documents are checked and candidates can then enrol for a course on the spot.

#### *The Real Dream Educational Consultancy*

This was one of the agencies most talked-about by nurses in Kathmandu, in relation to brokering nurses to Britain. I also met many nurses in Britain who were facilitated by Real Dream. Nurses told me that initially Kailash, a Nepali citizen, came to London in the early 2000s as a student (his course is unspecified). Later he returned to Nepal to marry a Nepali nurse. The couple came to London and found a nursing job for her in London. After she was established, some other nurses started making enquiries about

job opportunities in Britain. Through her connections, the couple started helping nurses to find jobs. By 2004-05 it had become a proper business. They then set up an office in Baluwatar in Kathmandu. A while later the Kathmandu office was moved to Naya Baneshowar, and Kailash's brother Basanta was coordinating the agency from Nepal, while Kailash himself and his wife were based in London, networking with healthcare agencies in Britain and arranging placements for Nepali nurses. They managed to recruit many nurses and sent them to the UK. The exact number is not known, but nurses I spoke to estimate it as over one hundred. These nurses were charged large sums of money for this service (between £3000-6000 depending on the type of visa nurses wanted to apply for). A visa with a work permit cost more than a student visa. After arriving in the UK, however, many nurses did not secure appropriate jobs and instead were stranded with no money, no proper job, and no work permit. This news filtered back to Nepal and was published in a Nepali National daily newspaper (Acharya 2006). This seriously affected the business and it started going downhill. Basanta, who was coordinating the business in Nepal, was being put under pressure by nurses' families in Nepal. Finally, in around 2007, the Real Dream office in Nepal was closed, and the younger brother also moved to London. In London too, Kailash was pressurised and criticised by Nepali nurses. They were rumoured to have made so much money that they have bought a family house in west London. A nurse who was brokered by the Real Dream told me that Kailash gives nurses a fake mobile number, or changes his number so no nurse is able to contact him further.

Nepali nurses who were based in the UK told me that these two agencies, the Real Dream and the Versatile Educational Centre, had merged in London in around 2006-07. They developed a new link with the London Thames College, as well as Stratford College and were still trying to broker nurses (and many young students) to the UK for work and study.

*UK/US Council, Naya Baneshowar, Kathmandu*

This consultancy was mainly involved in brokering nurses for NVQ training in the UK. It was not known when this consultancy started, but it was rumoured to have closed in late 2007. In autumn 2006, I met and interviewed the managing director Mr Jordan. I have also met many Nepali nurses working in the UK whose migration was facilitated by him. Mr Jordon informed me that the UK/US Council had the main link

with AIMA Services in the UK, which had networks in many places in India and the Philippines and a branch office in Kathmandu.<sup>64</sup> According to the website, AIMA has links with six British Universities: University of Sunderland, University of Glamorgan, the University of Worcester, University of Ulster, York St. John's University and Middlesex University. The AIMA website provides a clear picture on how these consultancies work globally as well as in the UK. When I met the manager of the UK/US Council in autumn 2006, he informed me that he had successfully facilitated over a hundred Nepali nurses to gain UK visas.

A senior nurse in Nepal in autumn 2007 claimed that, in spring 2007, the UK/US Council had developed some links with a nurse's recruitment agency in Australia. Between them, they recruited around 30 to 40 Nepali nurses and sent them to Australia with false promises that they would get jobs there easily as qualified nurses. When the nurses reached Australia, however, they were given different jobs, not nursing jobs. They had no choice but to accept low-paid and low-level unskilled work. The story reached Kathmandu, and the nurses' families who demanded the money back. The managing director was threatened with court proceedings but he disappeared suddenly and the office folded. This agency no longer exists in Kathmandu and nurses have no knowledge of its whereabouts.

These three agencies by no means control the whole 'Study Abroad' market in Kathmandu. A nurse I met in rural Northumberland was facilitated by an agency called CMS or Complete Management Solutions, based in Thamel, Kathmandu. She further informed me that CMS has linked with BSL or Blessed Service Limited UK.<sup>65</sup>

Not only are these IECs well-linked with international nurse recruitment markets, but they clearly make good money from nurses' migration. This is fairly evident if one calculates the resources they invest in advertising their products. They advertise on the radio and in newspapers almost daily. As already described, national newspapers have a large daily section of "study abroad" advertisements. In their glossy booklets and on their big billboards advertisements state that clearly they can help people to go abroad.

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<sup>64</sup> See <http://www.aimagroup.co.uk/> accessed on 27<sup>th</sup> of June 2010. Although the UK/US Council was closed in 2007, but AIMA still has a branch office in Kathmandu.

<sup>65</sup> Detailed information about BLS is available in their website. <http://www.blessedservices.co.uk/> information accessed on 12<sup>th</sup> of February 2009

## **B. Migration steps; choosing destination and entry visa**

Although western nursing jobs are regularly advertised in Nepal, they are not so easy to obtain. Obtaining a British visa is one of the most difficult steps for most Nepalis. Nurses seek for help from migration brokers and/or help from family and friends who are already living in Britain, or elsewhere in the world. Nurses research and consider any entry route, be it direct or indirect, as it is necessary to enter the UK first, and then start the process of obtaining a British nursing licence and then a nursing job. The process of visa application recently has become even harder, since the NMC implemented new registration policies for overseas nurses in summer 2006. Chapter Five will further explore the registration regulations.

Making migration decisions, and deciding where to go, also depends on information available on the destination country's immigration policy and regulations. For example, in 2002-03, many Nepali nurses managed to obtain work permits or adaptation students' visas easily to travel to the UK, so the UK was then the first choice destination for them. In 2006-07, after the changes with NMC and UK visa and work permit regulations, the nurses' migration flow seems to have diverted from the UK to Australia and New Zealand. Additionally, in 2006-07, some nurses came to the UK as higher education students, as National Vocational Qualification (NVQ) students. From late 2006 migration brokers in Kathmandu started advertising NVQ level 3 or 4 training, instead of work permits or adaptation student visas. As brokers started advertising for NVQ training, nurses started applying for NVQ student visas. Others came as dependant family members, or by whatever way seemed possible.

### *Why the UK?*

I asked Nepali nurses why they had chosen to migrate to the UK. Here is one response:

I had some romantic images about the UK. I had this imagination that the UK was a *classical- place, with a preserved culture*, which I had seen in old English films. I wanted to come and see it and be in it.<sup>66</sup>

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<sup>66</sup> Interviewed on 1<sup>st</sup> of March 2007 in rural Oxfordshire.

For many, Britain conjures up images of pleasant countryside and gardens full of ‘fair daffodils’ (Philogene 2008). But these images have very little practical relevance in the making of migration decisions. Nurses make decisions based on the possibility of getting a visa or work permit to enter a country, which requires foreign nurses, and where entry visas are easily available, as well as ones with existing support networks.

Evidently, the UK is not all Nepali nurses’ first desired destination. Many try to go to the US first and, if this is not successful, they then try the UK. Kripa, for example, applied twice for a US visa, but was rejected both times. She was very disappointed and did not want to try again to go to the US. Having recovered from her disappointment, she went to a different IEC in Kathmandu looking for facilitation and advice. This IEC was recommended by her friend. There, she had a week-long visa interview training for the UK, learning how to present herself in a visa interview situation.

There are newly developed Diaspora networks in the UK. As Lietchy suggests, these networks provide information about the UK to those who want to migrate to the UK. For example, in summer 2007, I was told by some Nepali nurses from Wembley (London) that if I wanted a clear picture of Nepali nurses working and living in Britain I should visit Hastings. I was also told that many Nepali nurses and their families had settled there, and that it felt almost like a “mini Nepali village”. I visited Hastings in spring 2008. I present the Hastings connection as a case study as it shows the networks and connections behind the decision-making process and how routes and destinations are chosen.

Mrs Tuka Chhetri-Sandwell, a senior Nepali nurse, became the owner of St. Mary’s Nursing Home in St. Leonard-on-sea, near Hastings, in April 1988. From November 1999, she started employing Nepali nurses in her nursing-home, as adaptation students first, then as full-time employees. Her very first candidate was her own niece, also a Nepali nurse. After that, she managed to get work-permits for three others in 2000. From 2001, she started a link with the Innovative Forum in Kathmandu which was run by her friends Mrs Bijayas KC and Mrs Sabitri Basnet. At that time, she was the only person working in her nursing-home in Hastings with the right qualifications to mentor overseas nurses undertaking the adaptation course. Her nursing-home already received pre-diploma nursing students for placements and had links with the



University of Brighton. As it was already established as a nurse training placement, the nursing-home required no further adjustments to offer adaptation placements for overseas nurses. Later, she had many more Nepali nurses applying interested in adaptation. Accordingly she sent some staff for mentorship training to increase the Nursing-Home's mentorship capacity so they could take more Nepali nurses at any one time. Once they had two mentors in St. Mary's, they were able to take three students in a batch and those students were usually from Nepal.

I was informed about this by Mrs Bijaya KC, when I visited the Innovative Forum in autumn 2007. Mrs Bijaya KC was on holiday in early 2000 and she came to see Mrs Tuka Chhetri-Sandwell. They talked about the possibility of setting up a forum in Nepal and linking with the St. Mary's Nursing-Home in Hastings, and helping Nepali nurses to migrate to the UK to work. By then, there were many Nepali nurses already here in the UK and Mrs Tuka Chhetri-Sandwell had been running adaptation training in her nursing-home. She had some experience on how to run this and deal with immigration and work permit regulations. Mrs Bijaya KC had contacts with many nurses in Nepal who wanted to move to the UK. They both agreed to enter a partnership that would entail offering nurses some pre-departure training in Nepal, which would help them select suitable candidates for the British job market.

When I visited the Innovative Forum in Kathmandu in autumn 2007, I spent several hours with Mrs Bijaya KC. She who told me their main selection criteria were that nurses should be physically, mentally and professionally suitable. On this basis, the Innovative Forum started selecting, training and sending candidates from Kathmandu to Hastings. In Hastings, Mrs Tuka Chhetri-Sandwell did all the official work regarding the visa applications required. A list of interested nurse candidates was created and, very quickly, a waiting-list was in operation. As soon as a place was available, Hastings would get the message and the next candidate would come. Officially Mrs Tuka Chhetri-Sandwell could not take more than three students at any time, because of the training and mentoring capacity.

Mrs Tuka Chhetri-Sandwell told me that she ran this training until 2007. By then, she had trained 107 overseas nurses, 30 from India, one from Burma and the rest from Nepal. Then, she sold her nursing-home she started working in St David's Nursing-home as a part-time manager. She updated her mentorship training and continued

offering supervised placements for overseas nurses. Since the NMC-UK changed the regulation in July 2006, on adaptation training and made it ONP, she has trained two nurses from St. David's Nursing-home; one Chinese and one Nepali. The most recent group started in November 2007 and they completed the training in March 2008. The Hastings and Innovative Forum link has stopped recruiting and training nurses from Nepal and sending them to the UK, mainly because the NMC changed its policy and regulations on overseas nurses' registration in 2006.

Since these changes, the registration process has been much tougher and quite rapidly the migration destination for Nepali nurses has had to change. This is one of many factors directly impacting nurses' choice of possible destination.

### *Choosing an entry visa*

The British government has various types of visas for foreign nationals to enter Britain. Choosing an entry visa totally depends on the type of visa Nepali nurses are most likely to obtain, and on this they are usually guided by IEC agents and other social and personal networks. In 2007-08, in Kathmandu, it was common knowledge in Kathmandu that one could bribe the visa section staff in the British and US Embassies and get a visa, and that International Educational Consultancies knew how to do it. It costs for example more than 10 lakh Nepali rupees (£8000-9000), for a US visa and between 4 and 6 lakh (£3000-5000) for a British one.

A nurse I met in Scotland told me that she chose to get a visa with a work permit, although it was much more expensive than a student visa. She was not talking about the visa fee *per se*, but the agency consultancy fee for helping her with the work permit process. Many nurses prefer work permits as they give at least five years' job guarantee, and they claim that it buys a five years of mental peace and security once they arrive in the UK.

Around 2003-04 many nurses were granted work permit visas, but it has been increasingly difficult to get work permits since 2006. Nurses I met in Britain had obtained one of the three types of entry visas.

*Entry as an adaptation student, or a work-permit holder (profession-related route)*

Of the three routes most nurses come to the UK, two are directly related to the nursing profession: as an adaptation student or with a work permit, but either way as a professional nurse. Nurses have used one of the IECs in Kathmandu or used their personal or social networks to facilitate taking these routes. Those without contact with the Innovative Forum in Kathmandu, or contact with Mrs. Tuka Chhetri-Sandwell in Hastings, have mostly used IEC agents. These agents play multiple roles, from helping nurses to get bank statements and language training to visa interview training. Their fee is at least three to five times more than coming via the Innovative Forum and with Mrs. Tuka Chhetri-Sandwell's help. Namrata, a nurse working in Hastings shared her experience:

I went to the Innovative Forum to get help for the visa and work permit stuff. The Innovative Forum guided me for all requirements and helped me to contact Tuka Madam in Hastings for further help. I also went to the Real Dream for the initial application procedure for NMC registration. I paid the Real Dream a small fee of 5000 Nepali rupees (approx. £40) for this. The Innovative Forum showed me the way.<sup>67</sup>

Mrs Tuka Chhetri-Sandwell applied for and got a work permit for Namrata and sent it to Nepal. In Nepal Namrata was waiting for work permit documents from Mrs Tuka Chhetri-Sandwell and, when she received these documents, she applied for a work permit visa. For that she submitted the document from Mrs Tuka Chhetri-Sandwell, her personal bank statement, work experience letter, CV, IELTS score, etc. Namrata got a visa easily without any problem. After obtaining her visa, she had a short preparation training from the Innovative Forum. For this training she gave a "donation" of about 20,000-25,000 Nepali rupees.

Those who had the Innovative Forum and Hastings connection experienced a much smoother processes of migration and job and social assimilation. I summarise this process below:

- Nurse visits the Innovative Forum in Kathmandu to start the migration process
- The Innovative Forum contacts Mrs Tuka Chhetri-Sandwell in Hastings
- Candidate put on a waiting-list for adaptation training
- The Innovative Forum gives them some basic orientation training

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<sup>67</sup> Interviewed in Hastings, February 2008.

- When a vacancy arises in Hastings, Mrs Tuka Chhetri-Sandwell will apply for a work permit.
- The visa application starts in Nepal, and if successful -
- Nurse flies to London
- Picked up either by friends at London Airport or takes a taxi to Hastings
- Nurse's accommodation is set up
- Adaptation training starts a few days later

Mrs Tuka Chhetri-Sandwell had not the capacity to cater for all interested candidates so many nurses have tried other routes to the UK. Sara, for example, applied for a different type of entry visa:

Radha: You wanted to come here to work as a nurse? Now you are doing NVQ, any plan for ONP?

Sara: "No, not at the moment. It is almost irrelevant now. I am hoping to complete my NVQ training first. Then I will see what happens".<sup>68</sup>

Sara told me that her main reason for doing nurse training was that this qualification would enable her to come to the UK. Nursing was not her ideal profession. She would have liked to be a teacher but, as a Nepal-trained teacher, she would not be able to migrate to the UK. She comes from a relatively well-off family. Her parents ran their own private boarding-school in Kathmandu. Her younger brother was also in the UK. She went to a private school and did well in her SLC exam and then studied nursing in a private college. After graduating as a nurse, she worked as a health educator for two years, before she came to Britain. Her parents gave her full financial and moral support while doing her preparation. She found a newspaper advert about NVQ opportunities in the UK for Nepali nurses. She followed it up, went to see the manager of the International Education Consultancy, the UK/US Council, in Naya Baneshwar. The consultancy fee she paid was £5000.00 and she came to the UK.

Kiran chose the same entry visa. She said:

...I don't know what I was thinking at that time I thought, just coming here and stepping on to British soil would be enough for me. That was my *mentality* then. Jordan [the IEC agent] would say nice things, because this is his business. He would speak very well. And I did the IELTS preparation course there in his consultancy. He teaches

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<sup>68</sup> Interviewed on 1<sup>st</sup> of March 2007 in rural Oxfordshire.

very well too. But that was his business; he would do anything to run his business. It is our weakness too. He charged for his service, I got my visa. I as an educated person with BN, if you click onto the internet you get so much information about NVQ, but I did not do any of that. I just trusted Jordan, that was my weakness and I realise it now. I wanted to come to the UK. There were other ways as well, but I thought this way would be the quickest and easiest one. I paid money and I got my visa within a month.<sup>69</sup>

### *Entering as a Masters degree or further education student*

The desire to migrate to the UK appears so strong, that some Nepali nurses come as students. I interviewed one nurse who came to do a Masters degree and who did not return to Nepal after she finished her course. Several informants, however, claimed that there are many nurses who entered the UK for further studies and, who extended their visas when they completed their courses. They applied for a “fresh talent visa” or, as it is also known, a “post-study visa” or have extended it in some other unspecified way.

### *Entering as a dependant wife*

Coming to Britain as a dependant wife or family member appears easier, and allows more flexibility in getting jobs. This route is a new phenomenon in Nepal. This has not been discussed much in nurse migration literature, but is widely talked about in Nepal. Many young non-resident Nepali men return to Nepal to look for marriageable nurse brides. For example, in autumn 2007, I was in a newly-opened private nursing college in Kathmandu. I asked the college Principal why so many BSc. Nursing programmes are running in Kathmandu. Her response was:

...nurses are needed everywhere including for Nepali bachelor boys living in western countries. They write to their parents asking them to find nurse brides so they can take their wives back to the west and they can get employment easily there.<sup>70</sup>

At first I thought she was joking, but later I realised that she was quite serious. In fact her nephew, who lives in the US, had written to her family asking them to find a bride. I met many other nurses who told the same stories. The office secretary in the Nursing Association of Nepal made similar comments, when I was there in autumn 2007. This issue has also been highlighted by the Nepali media (Ghimire 2007). In a casual conversation in Aberdeen in February 2008, a Nepali nurse told me about two

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<sup>69</sup> Interviewed on 10<sup>th</sup> of February 2008 in Hastings, England.

<sup>70</sup> Interview with Private Nursing College Principal, autumn 2007 in Kathmandu.

young men who had returned home to get married and were particularly looking for nurses. Two months later, I heard that these two men were back in Aberdeen, with their new brides, both nurses. I interviewed three nurses who entered the UK as dependant wives; one was working as a full-time nurse and the other two as nursing assistants.

Whatever entry visa nurses use, their ultimate aim is to obtain a British nursing licence, and work as a qualified nurse in the UK.

### **C. Preparation and visa application**

From the records I reviewed in Nepal, the most popular destinations were the USA, UK, Australia, New Zealand and Canada, although some Nepali nurses have migrated to the Middle East, Hong Kong, Singapore, and India. From the experiences of Nepali nurses in the UK, the focus of their preparation is on getting a visa. This preparation time seems one of the most emotionally tiring times. The migration outcome is totally dependent on obtaining a visa. All nurses have to submit all of the following documents with their visa applications: bank statements, adaptation placements or job placements or course confirmation in the UK; *nata pramanit* (family or relationship verification letter) in Nepal; property valuation, parents and family assets and a letter family support; an education qualification verification letter from the nursing college; and finally evidence of English language ability.

#### *Bank statements*

Most of the nurses I interviewed regarded bank statements as the most important documents. I was informed that one needs a 'healthy bank statement'. A healthy bank statement has a decent amount of money coming in and going out regularly (not just money sitting in an account stagnant, or a large amount of money coming in just once). Nurses I interviewed in the UK said they needed a healthy bank statement with at least six months account overview, to satisfy the British Embassy that this person has enough money and earning capacity, or that her family can financially support her. Healthy bank statements are made in two ways. The first is to use personal or family money, borrowing from relatives or finding a financial guarantor: some family member who has relatively sound assets and can act as a guarantor. All is done to

present evidence of a sound financial position. The second way is to go to the bank and arrange statements with the bank staff, paying the bank staff a service fee. The Himalayan Times classified section has multiple pages of advertisements every day. Usually one and a half pages of adverts relate to making healthy bank statements, and one of the most common advertisements is:

...if anybody needs a bank statement, contact this number, quick and reliable service with good rates.

After making enquiries in Kathmandu, I found out that some bank staff are involved in this complex business of falsifying bank statements to make them look healthy temporarily whenever needed. Suppose I need a statement because I want to migrate to Britain. I contact either the number advertised in the newspaper or an agent who is involved in making bank statements informally, usually through a friend or family recommendation. The bank staff will create an artificial account for me with a large sum of money, as per my request, but on one condition: that I have this account and money officially for show, but I cannot withdraw any money or use it at all. When the visa process is completed, all the money goes back to the real owner, or the bank staff. I have to pay a certain fee for this service. When the relevant visa office contacts the bank to check whether the statement I have presented with my visa application is genuine, any bank staff member can log-in to this account and say “yes”. It seems that this is big business and many bank staff are involved in it. They put their collective savings temporarily into the fake account, and when they get the fee for this service they share it amongst themselves. Many educational consultancies have links with banks in Kathmandu. So far, no bank staff have been officially investigated for being involved in this type of bank statement ‘scam’.

The majority of nurses I interviewed were from relatively wealthy families in Nepal, and many did not need to use this service, as the service fee is very heavy (up to 30,000 rupees or approx £200-300), but a few did. Others preferred to borrow money from their families and relatives. A nurse working in a rural nursing-home in East Sussex told me how proud she was of her family support. When she expressed her desire to migrate all her family members were very supportive. She needed to provide some financial evidence with her British visa application; even her husband’s family members lent her some money. She felt so proud and supported, she said:

For the first time in my life I felt that I was so important in my family, everybody, all my relatives were trying to help me in their own way. My sister-in-law lent me so much money; I felt I was special.<sup>71</sup>

Because of this growing business of creating bank statements, one nurse said the British Embassy visa section was becoming suspicious about the bank statements people present with their visa applications. Now these are examined more strictly than ever before, and many visa applications are refused on these grounds. A nurse, whose British visa application was refused, said:

The visa section staffs are getting increasingly suspicious; some nurses' visa applications were rejected on this ground. My application was refused when I tried first time, they said my bank statement was false, but it was genuine. I had shown my father's money and property valuation report, but the Embassy thought that it was all false.<sup>72</sup>

I met two nurses in Nepal, who had applied for British visas: and their applications were refused and they thought it was because of their bank statements. Such experiences are widely discussed in Kathmandu.

#### *An offer letter for a course or training*

Nurses also need a letter from the UK offering a job, course, training or adaptation placement. The majority of nurses (except those who entered as dependant wives or as masters' students) have had help for this from IECs and the Innovative Forum in Kathmandu. Most IECs in Kathmandu are linked with private colleges in the UK such as Tudor College in London, Thames College, and Greenwich College. If consultancies or agents are involved in making these documents, they charge service fees. Nurses I interviewed admitted that documents related to training or courses supplied by the agents were usually false, and the agents asked for these documents back when nurses arrived in Britain. Nurses who obtained these documents from agents say they did not know whether the documents were genuine or not, until they arrived in Britain. Later, they learned that some of the colleges used to create these documents did not even run these pre-adaptation, and adaptation programmes, as stated in their offer letter. One nurse who entered the UK as an adaptation student through the help of one of the agencies, said:

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<sup>71</sup> Interviewed on 2<sup>nd</sup> of April 2008, in Hastings, England.

<sup>72</sup> Interviewed on 27<sup>th</sup> of February 2007, in rural Oxfordshire.



I was very nervous when I learnt that I was travelling all the way to Britain and holding false documents. When the agents asked for all of them back after I arrived here, I said these were official, so legal, documents and I wanted to keep them with me. When I realised that they were all false, I destroyed and disposed of them. I was very nervous.<sup>73</sup>

Many nurses I met had such documents saying that they were enrolled for adaptation or pre-adaptation training in a certain college. Those who went to Hastings via the Innovative Forum in Kathmandu, however, felt that their letters were genuine. Those who had relations and family in the UK had a different set of documents. Other documents include NVQ training-related documents.

#### *Proof of family relations and property valuation letter*

These letters are made in Nepal, usually by the local authority. Their purpose is to show the Embassy that the nurse has family support and her family are financially sound. This provides support for their bank statements.

#### *Evidence of professional qualifications and qualifications verification letters*

All nurses submit these documents with their visa application. They get one from the Nepal Nursing Council and one from their training college. All of this documentary evidence, as nurses suggest, so far has been genuine (from nurses' testimonies and nursing college and NNC letters records).

Finally, some nurses have received visa interview preparation training. Many have had a course on English Language, and IELTS preparation. But the evidence of English language proficiency has been optional for many in the past (until July 2010) and still is not needed for those who come here as dependant wives.

### **Conclusion**

Recent social changes in Nepal and changes in media technology globally have created and fuelled the desire for educated and skilled Nepali professionals to go abroad. Globally nurses seem to be in a good position for these moves (Percot 2006; Kingma 2006) and this applies to Nepal too. Nepali nurses use various IECs and other professional, social networks and family connections. They receive full family

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<sup>73</sup> Interviewed on the 27<sup>th</sup> of February 2007, in Oxfordshire.

support in the fulfilment of their migration desires. They obtain entry visas, whichever type is most possible. However, not all fortunate enough to obtain an entry visa to their desired destination country. Those without professional or family links have little choice but to rely on the information given to them by the IECs agents, and the process becomes very costly and risky.

The IECs, have been frequently criticised by the media for providing false information to Nepali students and potential migrants. Stories of nurses being cheated by the IEC agents have been frequently heard (Acharya 2006). The Himalayan Times of 12<sup>th</sup> of November 2008, published an article by Subba, entitled “power of correct info” in which the Australian Ambassador, Mr Lade advised Nepali students to learn about the visa regulations and courses and universities in Australia, not just to trust the brokers (IECs) because some of the messages the agents give to the public turn out to be too good to be true (Subba 2008).<sup>74</sup> Similarly the US embassy in Nepal issued the following notice in January 2009 (Nepalnews.com).

We hear stories of unscrupulous consultancies offering packets of fake financial documents for sale or schemes involving a supposed 'job' in the U.S. for hefty amounts," Consul at U.S. Embassy Mea Arnold said in a press meet...

In Nepal, I met nurses, whose visa applications were rejected by the British visa office on financial grounds, meaning visa section staff were suspicious that bank statements were faked. Some had already paid the brokers' consultancy fees for future jobs or courses, but the brokers had not refunded their money and the nurses were very angry. Unfortunately, the information supplied by IECs usually seems to be false. However these brokers are incredibly clever. They can alter their strategies and quickly adapt to changing visa policies and regulations. Accordingly some nurses make visa applications several times and to multiple destination countries. Eventually though some obtain the British visa and come to the UK. What happens to the nurses when they arrive in the UK is explored in the following chapter.

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<sup>74</sup> [www.thehimalayantimes.com](http://www.thehimalayantimes.com); Kathmandu Wednesday 12th November 2008. The same article states that nursing is the fifth most desired course for Nepalis to study in Australia and student numbers had grown by 110% in 2008.

## **CHAPTER FIVE**

### **ARRIVING AND SURVIVING IN THE UK**

After obtaining a British visa, nurses waste no time in Nepal. They board the earliest convenient flight to London. After landing in London, as do all other migrants, nurses have to make many new adjustments. First and foremost, they have to find somewhere to stay, then find a job and start their lives in a new society. To work as qualified nurses they need to obtain the all-important British Nursing Licence, also known as NMC-UK PIN (Professional Identification Number). As already noted, changes around the NMC's regulation of overseas nurses' registration in 2006 have made the process of obtaining the NMC-PIN very tough. To be able to live and work legally in Britain, Nepali nurses need a valid visa and a work permit. For these they have to negotiate with ever-changing British immigration regulations. These steps have been major hurdles and challenges for many nurses and ultimately affect nurses' professional and social assimilation processes. Even after getting through these hurdles, they face the further new challenges of securing full-time, preferably permanent, jobs. As this research has demonstrated, none of these processes is in any way easy.

As seen in Chapter Four, the IECs and other professional networks play a major role in providing information and acting as intermediaries for nurse migration from Nepal. IECs assure nurses that they will help them find nursing jobs and assist them to obtain work permits in the UK. In addition to IECs, there are other social and professional networks for some nurses, and this support is also vital in the early days of migration. This chapter examines how nurses obtain their NMC- PIN in order to practise as qualified professionals, how they secure nursing jobs and work-permits and explores what support they receive from IECs and other social networks. I will begin by looking at the trend of Nepali nurse migration to the UK and then their first steps as they prepare to leave for a new life.

## **A. Nepali Nurses in Britain: migration trend and available data**

Available records and information on ‘out of country’ movements of nurses from Nepal suggest that Nepali nurses started coming to the UK mainly from 2000. Before 2000, only a few nurses came to the UK and then returned home, after a period of further education. Some nurses came as dependant family members, but the wider and organised nursing migration market that we see today did not exist. As I have highlighted in Chapter Four, initially, nurses’ migration evolved through personal connections. As we have seen, Mrs Tuka Chhetri-Sandwell, the Nepali nurse running a nursing-home in Hastings, saw the nursing shortage in Britain as an opportunity for Nepali nurses. There were many nursing vacancies in NHS trusts and in private nursing-homes. The Home Office had special work permit provision for overseas nurses so organising and obtaining a work permit was easy. Mrs Tuka Chhetri-Sandwell supported these few nurses to come to the UK first, after which many started making enquiries about the job possibilities, and the number started to rise, a pattern commonly described as “chain migration” (Ahmed 2005; Castle 2000). Gradually this developed into a thriving migration business, involving Nepali as well as British and other international recruitment agencies.

Finding exact data on migration has been a challenge for migration researchers globally (Castle 2000; Saravia & Miranda 2004; Diallo 2004), and finding any data on nurse migration from Nepal has been extremely challenging. There is no recording system in Nepal. I tracked available records on nurse migration, such as the NNC register; records kept at various nursing colleges on qualification verification issued for their graduates; the British Embassy visa section records and information from IECs. Drawing on this data, I estimate that by the end of 2008 between 800-1000 Nepal trained nurses had migrated to the UK.

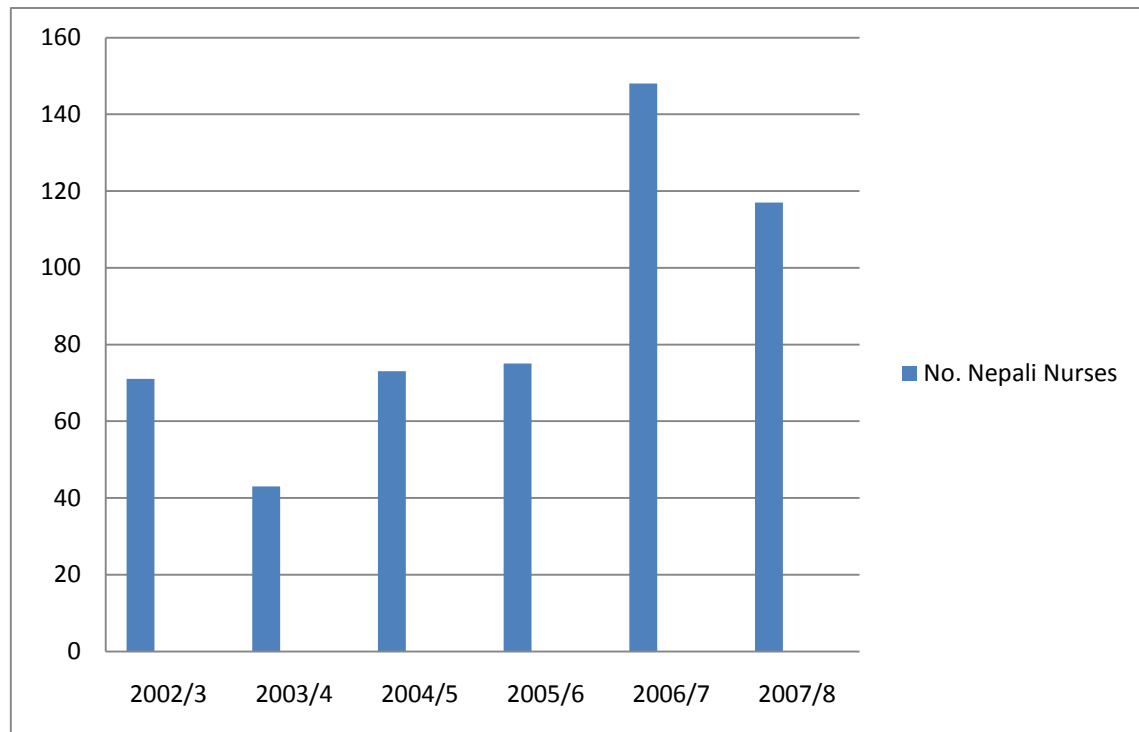
At the UK end, the NMC–UK is the professional regulatory body that keeps records of all suitably qualified and eligible nurses who are registered to practise as nurses in the UK. The NMC also has records of the country of origin of all nurses registered in the UK. Their nurse registration record starts from the first of April till the 31st of March each year. From this estimated total, the NMC records suggest that between 1<sup>st</sup> April 2002 to the end of March 2008, 527 Nepal trained nurses were entered in the NMC register as initial registrants, who then obtained a full licence to practise as

nurses (NMC 2009). A nurse's initial registration with the NMC does not mean, however, that s/he actually has moved to the UK to work. I have met many Nepali nurses in Britain who moved within two years after receiving NMC decision letter as they are valid for two years. Nurses need to find an adaptation training placement within this period. I think that this number is a reliable indicator of the number of Nepali nurses entering the British healthcare system. As well as official NMC figures, many Nepali nurses I met in the UK have entered as dependant family members, they were planning to make NMC registration application and in the mean time doing jobs not directly appropriate to their qualification. Prior to this, Nepal was subsumed under the category of "other" as the number of nurses entering in the NMC-UK from Nepal had been insignificant.<sup>75</sup> Before 2002, 162 Nepali nurses' applications had been processed by the NMC-UK, but it is not clear how many were actually fully registered and had obtained their PIN. When the NMC started its new recording system in 2002-03, Nepal was then listed as a new source country. In that year, there were 71 Nepali nurses registered, and Nepal ranked 24<sup>th</sup> in a list of countries sending nurses to the UK. However, in 2007-08 this figure rose to 117, and Nepal has become 5<sup>th</sup> in the hierarchy of source countries for overseas qualified nurses. Unfortunately, the NMC changed its website in Spring 2010. Now these data are not available, so it is not clear how many new entrant Nepali nurses have been admitted to the NMC register since April 2008.

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<sup>75</sup> E-mail communication with Public Relation Officer, NMC-UK, June 2007.

**Graph 5.1: Nepali nurses registered by year (April – April) in the Nursing and Midwifery Council** (Source: NMC-UK (2008; 2009) register-statistical analysis)



Apart from those registered on the NMC record, many Nepali nurses work as care workers and nursing assistants in the UK. Many hope to be fully registered nurses one day. During the research fieldwork period, some were preparing for the English language test required for the NMC-UK registration and others were already disheartened by the whole NMC-UK registration process and were looking for opportunities elsewhere.

Information obtained from the British Embassy in Kathmandu, and interviews with Nepali nurses in Britain, revealed that Nepali nurses obtained five types of entry visa to come to the UK. Three of them are directly related to their professional work, and two other types include a dependant family visa, and a student visa to do post-graduate degree courses. Nursing-related visas are subdivided as we saw earlier into the following sections.

### *National Vocational Qualification (NVQ) level 3 or 4 student visas*

Nurses who obtained this visa are meant to do Health and Social Care level 3 or 4 training. This does not directly lead nurses to register with the NMC-UK to obtain their full nursing licence to practise, but it was perceived as a way to get into the UK. These courses are provided by colleges and higher education authorities in the UK. Nurses were told by IECs in Nepal that the course usually lasts for 12-18 months, so the nurses I met who had this type of visa had initially 18-month student visas.<sup>76</sup>

### *Overseas Nurses Programme (ONP) (formerly known as Adaptation Course Visa)*

Until July 2006 this used to be called Adaptation Course or Supervised Practice placement, but the training was renamed as Overseas Nursing Programme (ONP). Before the changes occurred in 2006, this training was available for overseas qualified nurses, within the NHS or in private-sector healthcare institutions, where there was an NMC-recognised and qualified mentor who could supervise, support and assess an overseas nurse to obtain full NMC registration. When a mentor judged an overseas nurse to be ready, the mentor would recommend her for full registration with the NMC. After the changes in 2006, the ONP came to be offered by higher education authorities in the UK. Entry into the ONP is very difficult currently, as very strict entry criteria have been introduced (NMC 2010).<sup>77</sup>

### *Work Permit Visa*

Between 2000 and 2004, the recruitment of overseas nurses was active and nursing was registered as a “shortage profession” by the Home Office, UK. Healthcare institutions then, could fast-track work permits when they employed overseas nurses, and overseas nurses would be granted Work Permit Visas to work full-time in the

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<sup>76</sup>I received this information from the British Embassy in Kathmandu. The NVQ level 3 and 4 is not run by the NMC. It is a course run by many private colleges. It does not lead to registration with the NMC which would allow the holder to work in Nursing in the UK. It does not have an IELTS - an International English Language Testing System - requirement as one of its entry criteria. Those who successfully complete an NVQ level 4 course usually end up working as carers as the course does not qualify them to work as nurses. But the *ONP* is approved by the NMC. Successful completion of this course leads to PIN registration which allows the holder to work in nursing in the UK. E-mail communication with the consular in the British Embassy Kathmandu in December 2006.

<sup>77</sup>Entry criteria for ONP are: a) an overseas qualified nurse should have a valid NMC decision letter; b) IELTS score 7 in all categories. Many Nepali nurses find it very hard to obtain the required IELTS score; and c) Those who are already living and working in the UK get priority.

NHS and in private nursing-homes. Those nurses I met who had a four-year Work Permit Visa, obtained them from the British Embassy in Kathmandu. This allowed initial pre-registration training and led to work as fully registered nurses afterwards. Work permits were however, tied to a workplace where employees were to stay for four years. If they changed their jobs, their work permit became invalid, so they would need a new one to work in a different place.

### *Leaving Nepal*

After all the effort of obtaining their visas, and before leaving home, prospective migrants, be they either skilled professionals or students, have parties and celebrations. This is a common social practice in Nepal. For the nurses who do get visas, the last week before they leave home is usually very exciting, and is a week filled with happiness at the success of obtaining the visa, as well as being busy with preparation for departure. After all the celebrations in Nepal, finally the nurse arrives in the UK. With the initial arrival experience nurses, express a sense of relief on clearing emigration in Kathmandu and, after a long journey, entry clearance in Britain. As I have discussed in Chapter Two, Kathmandu airport emigration clearance is everybody's nightmare, but is particularly difficult for women travelling on their own. Of the nurses I interviewed, their early arrival experiences seem to have been mixed; both a dream come true and a tremendous amount of anxiety and feelings of insecurity. However, they have yet to face challenges of NMC registration and professional assimilation.

### **B. Professional assimilation in the UK**

Professional assimilation begins with becoming eligible to practise nursing in the UK and obtaining an NMC PIN. For this, Nepali nurses have to go through an adaptation or ONP course. One nurse I interviewed, Moti, went through a very stressful period of over a year after she arrived in the UK, but other nurses had a smoother time comparatively. How smooth and quick the process is, depends on two main factors: the timing of their arrival and how well nurses are connected and supported by existing *social and professional support networks* once in the UK.



The NMC is an independent professional regulatory body for all qualified Nurses, Midwives and Health Visitors in the UK. All qualified nurses who want to practise nursing in the UK must register with the NMC by law. It sets all standards and practice regulations, which all nurses, midwives and health visitors must follow. Registration criteria for overseas trained nurses are also determined and set by the NMC. As already noted above, in 2006 there were some changes with NMC registration for overseas trained nurses. Most Nepali nurses who participated in this research had obtained their NMC PIN before the changes occurred, with only a few obtaining them after July 2006. As such, it is important to examine both the old and present NMC registration regulation, and it is to this issue I now turn.

#### *NMC-UK registration regulation--pre July 2006*

Until July 2006, the registration policy and decision-making about any overseas nurse would be made on an individual basis. The NMC would issue a decision letter to an overseas applicant, after careful examination of the applicant's initial training and subsequent work experience in her own country. The most common decision given to Nepal trained nurses used to be that applicants were to complete a period of supervised placement, in a healthcare establishment, in the UK. The time for this could be between three months to one year, depending on when an overseas nurse's clinical supervisor/ mentor felt that the nurse was ready to practise independently and safely. The placement would be anywhere deemed suitable for pre registration nurses to train, for example in an independently run nursing-home or in an NHS hospital ward. The organisation however, regularly informed all overseas applicants that there were only limited numbers of training places available in the UK, so overseas nurses were not to travel to the UK until they had found suitable placements.

Many overseas nurses found it impossible to find a training placement in the UK whilst living in their home country. Despite the NMC's advice, Nepali nurses would try and come to the UK first, then search for a placement afterwards. Their explanation for this was that the NMC decision letter would be valid for only two years, and so they would try and find a placement within this period. Many felt that, if they followed the NMC's advice they would never make it to the UK.

Some nurses I met and interviewed said their NMC decision letter expired while they were waiting for suitable placements in the UK, so they had to start the whole application process all over again. This meant further payment, and it became very costly. Some arrived just a few months before their NMC decision was to expire. Yet, even though overseas nurses faced all these practical hurdles and difficulties with finding an adaptation course placement, the NMC continued to receive increasing numbers of applications from overseas.

Crucially there were few suitable places for overseas nurses' adaptation training, and the capacity of those facilities remained small. A large number of overseas trained nurses were already in the UK. Joint research by the Open University, the University of Surrey and the RCN on "Overseas Nurses and their career progression" suggested that, in 2006, there were over 37,000 nurses waiting in limbo for suitable placements for adaptation training and supervised practice placement (Smith *et al.* 2006; Parish 2006). At a time when so many overseas nurses were desperate to undergo the training process, the NHS stopped employing overseas nurses and the Home Office changed UK work-permit regulation. Parish described this situation as "the tap has now been turned off mid-flow" (2006:7).

Kingma points out that some private agents saw this gap as a business opportunity. They started charging heavy fees for adaptation training placements but without providing much required supervision and guidance. A private nursing-home mentor allegedly provided mentorship to 113 overseas nurses in a period of three months, which, as the author points out is a physically impossible task (2006: 101). This trend was associated with sub-standard monitoring and proper regulation of private-sector training placements.

The British media then began to report that many home-trained nurses were remaining unemployed (Hancock 2008). Simultaneously, because of economic constraints, the NHS employment capacity was reduced in 2005-06, and this situation worsened opportunities for overseas nurses yet again. In order to combat the UK situation, stricter regulation was thought to be needed, and the NMC changed registration regulation accordingly. This new regulation for overseas nurses' registration was designed and introduced, coming into effect from August 2006.

### *NMC new registration: the Overseas Nurses Programme (ONP)*

In 2010, under the present NMC regulation, for registration purposes, all overseas trained nurses are placed in two categories: nurses trained in the European Union (EU) and secondly, nurses trained outside EU countries. Registration eligibility for overseas trained nurses is decided by the NMC (as it was before August 2006) on an individual basis, depending on the nurse's original training and subsequent work experience. According to the new regulation, nurses from the countries outside the EU have to obtain an English language test score of 7 in all areas including listening, reading, writing and speaking skills. This International English Language Testing System (IELTS) test score has been a tough challenge for many. A NHS nurse manager, involved in running training for overseas nurses, informed me that "this was deliberately introduced to control the number of overseas applications".<sup>78</sup> Since the new NMC regulation came into practice, the number of overseas nurses' applications has significantly decreased. According to the NMC, in May 2008, this figure came down to 193.<sup>79</sup> During this research fieldwork, and at the time of writing this thesis, many Nepali nurses in the UK, were still waiting to be registered but were held back, because they are unable to obtain the required IELTS score.

Once nurses obtain an IELTS score of 7, they are eligible to enrol for the ONP. The ONP is designed to offer nurses better training, supervision and support. It has 20 days of protected and structured learning with a three-month period of clinical placements. All the ONP courses are standardised and the supervised clinical placements are properly monitored, as to their suitability, by a local higher education authority. There are now only 50 ONP training programme across the UK, approved by the NMC, including 3 in Scotland (NMC 2010). Courses cost different amounts of money in different centres, but can cost up to £3000.

When nurses complete this training they receive recommendations from their clinical supervisors for full registration as qualified nurses. Then they pay a further

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<sup>78</sup> Interviewed in summer 2006, NHS Lothian, Edinburgh.

<sup>79</sup> E-mail communication with the Public Officer NMC, May 2008. How this number came down to 193 from over 37,000 is not clear. One possible reason could be that many overseas-trained nurses gave up with NMC registration or were just removed from the NMC list, as their prescribed period for adaptation/ONP training expired.

registration fee and obtain their PIN. This registration now has to be renewed annually.

### *Experience of adaptation training placement*

Sixteen out of the twenty-one Nepali nurses I interviewed in Britain have their NMC PIN. Fifteen of them had completed their adaptation training in private nursing-homes.<sup>80</sup> Three of my respondents had had no luck with finding adaptation placements or ONP, and two nurses were under ONP training at the time of my research interview. The majority of nurses who completed their training in nursing-homes felt that the adaptation training was very useful, but only for work in a nursing-home situation and in long-term care settings. Most nurses found it inadequate for learning and practising any advanced clinical nursing skills, required for work in an acute clinical setting in the UK.

Most felt that, during their adaptation period, they were not fully supported by experienced mentors, but rather policed by care staff less qualified than them. They expressed that quite often they were left with care assistants. Lila for example was left with a carer during her adaptation in a nursing-home. She said:

How can a carer help me to learn about nursing in Britain? What could she teach me - she could not even read patients' notes herself?<sup>81</sup>

Lila already had a Master's degree from Nepal and felt humiliated being supervised by care staff in a nursing-home. She revealed that there were insufficient properly qualified and experienced mentors in the nursing-home, where she was undertaking her training, to provide much-needed support for her. This nursing-home was staffed mostly by care staff, with only one or two trained staff on each shift, who were to distribute medicines and take charge of the shift. However she had no other options.

Those who obtained registration through the old system (pre- ONP) have suggested that policy and regulations were unclear and inconsistent. Nursing-homes had no standard training criteria and guidelines. Kingma (2006) and RCN (2003) have also highlighted this point that some privately-run nursing-homes were not monitored and

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<sup>80</sup> Except one who found an NHS adaptation placement, as she came here as a dependant wife so she did not require an adaptation student visa or work permit.

<sup>81</sup> Interviewed on 19<sup>th</sup> January 2008, Aberdeen, Scotland.

audited rigorously at all. Nurses' named mentors existed only on paper, and many felt that the whole training programme was left up to their mentor alone. Even if not working closely together, maintaining a good personal relationship with one's mentor is vital, and the better the relationship with a mentor is, the easier and smoother the training becomes. Although the quality of training they received was not of a high standard, many felt it was very important for them to complete it as quickly as possible. Most nurses were so desperate to obtain their NMC PIN, so they could look for proper nursing jobs.

### *Job market / work permit situation and nurses' experience*

After completing their training and obtaining an NMC PIN, for some finding a full-time nursing job has not been easy either. Even those nurses who had already obtained their NMC PIN have worked only part-time in nursing-homes, as bank nurses, for months and even years. I found it hard to understand why they could not find a job, while the RCN claimed that Britain needed many more qualified nurses, and that hospitals and nursing-homes have been chronically under-staffed (RCN 2009). Usha, for example, travelled to Scotland from the South-east of England for a job interview and shared her experience:

I have been to so many places, almost every major city in Britain. I went to Ireland, Wales, and many places in England for job interviews. I have done my adaptation training and have obtained my PIN. But, finding a job is difficult. I asked for feedback after my interviews, they say that I did well and it was good, but I just don't get a job offer. My suspicion is when they learn that I need not just a job but a work permit as well, they just say sorry... I have over twenty years of working experience in Nepal. Presently I have a student visa, which allows me to work only 20 hrs a week, but I need to work more than this in order to survive in this country. I don't understand why I don't get a full time RGN post.<sup>82</sup>

In March 2009, she secured a full-time RGN post in a rural nursing-home in Scotland. It took her over a year to find a proper job and work permit after obtaining her NMC PIN. She wanted to invite her children and husband over, who were still in Nepal, but could not do that until she had a full-time job and work permit visa. I have met many others in the same situation who eventually found nursing-home jobs, but only with much difficulty. Most suggested that the Department of Health in England's Code of

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<sup>82</sup> Interviewed on 2<sup>nd</sup> of April 2008, in Hastings, England.

Conduct and the Home Office work permit policy were the main barriers for finding nursing jobs in the UK.

*Department of Health's (DH) Code of Practice for the International Recruitment of Healthcare Professionals (2004)*

In the late 1990s, as many nurses from developing countries or resource-poor countries started coming to the UK, the inflow of nurses to Britain started to rise. Initially, many were coming from South Africa, while in South Africa the country was experiencing an acute nursing shortage. Nelson Mandela, in his visit to Britain in the early days of the Labour government in 1997, asked the British Government not to recruit nurses from South Africa. He used his charisma and political leverage to ensure the British Government banned nurse recruitment from his country, utilising a humanitarian argument (Kingma 2006: 126-7). In 1999, the DH in England produced a set of guidelines that prohibited the NHS from recruiting nurses from South Africa. These guidelines were further expanded in 2001 to include the Caribbean. In 2003 a longer list of developing countries was added. Nepal was put on the list then. Finally in 2004, the guidelines were yet further expanded to cover other categories of health workers, not just nurses.<sup>83</sup> Although these guidelines were designed by the DH in England, as 90% of internationally recruited nurses were working in England, the guidelines were intended for the NHS of all four countries in the UK.

However this code is only a guideline and is not mandatory for British employers. It has no formal legal basis. While it bans active recruitment of nurses from under-developed countries such as Nepal, it also says that, if a nurse from one of the banned countries seeks employment in the UK individually, this is not restricted, at least in theory. Additionally the guideline is clearly for the NHS trusts, and the fast growing private sector is not covered. These guidelines have also been criticised, as it is argued that they have no real effect on nurses coming to work in Britain from the very countries from where recruitment is banned, because of “back door” recruitment (Buchan 2004). Nurses from the banned list of countries would come to Britain and work in the private sector for a while, then gradually enter the NHS. Further, this ban has actively diverted overseas nurses to the private sector, where the DH guidelines

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<sup>83</sup> In fact the DH England prides itself for being the first country in the world to develop ethical guidelines for international recruitment of nurses and health workers (DH 2004).

are not followed and where chances for a work permit visa for overseas nurses were higher, at least until 2006. It seems that the very policy intended to make the NHS an ethical employer, has almost certainly had “unethical” consequences, as it has created a wider space for international recruitment agencies to link up with private nursing-homes in the UK, where overseas nurses are regularly exploited. Neither the DH nor the NMC or any other authorities appear to have much control over this.

### *Work permit visa regulation and Nepali nurses’ experiences*

An appropriate British work permit visa is required to work in Britain. Work permits are given when there is a direct agreement between two governments or in the case of nurses, when nurses are recruited directly from outside EU countries to fill the vacancies that have not been filled by local, regional and national recruitment efforts. There has, however, been no direct agreement yet between the Nepali and British governments as regards to work permits for Nepali nurses.

Even before the Home Office regulation changes, work permit policy was not clear to many nurses. A nurse working in Scotland in 2008 informed me that when she was making work permit enquiries from Nepal, she was told it would cost her an extra £1000, on top of other agency charges. She thought it was a genuine official fee so paid this amount and got a work permit to work in a nursing-home in England. But she could not explain the whole process any further as she did not understand much about the regulation process herself. Another nurse I met in Scotland said that she had a choice of a work permit or a student visa while she was preparing to come to the UK in 2004. She was also told by an agent that the work permit costs were about £6000 in total (including finding a job and adaptation placement in a nursing-home) but that the adaptation student visa would cost only £3500.

Not only nurses, but also private nursing home managers are unaware of the work permit process, as many nurses’ stories suggest. After receiving her NMC PIN, Kiran, whom I met in Hastings, started looking for a full-time permanent job. She applied for many nursing jobs, and was offered a job interview in a private nursing-home in Wales. She went for the interview and was told that she had been successful. She was delighted, as she desperately needed this job to live and work in the UK. When her employers tried to fast-track a work permit for her however, the Home Office refused

it, on the grounds that the employer did not follow the correct procedure while offering the post. Kiran felt that the employer had not followed the guidelines for hiring a nurse from outside the EU.<sup>84</sup> As a consequence, she did not get this job.

These guidelines for recruiting and employing health workers from outside EU countries are monitored, and all procedures are examined when the Home Office issue a work permit visa. An employer must submit an application for a work permit to employ nurses from outside EU countries. Once a work permit is obtained, the employee has to go to the Home Office, with the work permit document, to have a work permit visa issued. If a nurse changes her employment, she has to obtain a new work permit for her new job. Kiran said that, because of complicated bureaucratic process, private sector employers are becoming increasingly hesitant about employing nurses from outside EU countries. Once an employer obtains a work permit from the Home Office to employ a particular person, this has to be transferred into the employee's passport. Some other nurses I met had received their work permit documents, but their work permit transfer to their passports was still refused by the Home Office. These nurses could not understand nor explain why these had been rejected. Some suspected that they were the victims of random Home Office harassment. I interviewed Sheila in Kathmandu in autumn 2008, and she told me that, despite going through the correct employment hiring procedure, she was refused the transfer of her work permit visa to her Passport.

I went to Kemnay, in Aberdeenshire in October 2006. My visa was valid only until December 2006. So, I was under pressure to renew it and get an appropriate work permit. Soon after I started working in this nursing-home, the home manager started the work permit process, she sent some forms to the Home Office, but it took a long time to get any response. I made several enquiries and finally I learnt that the form the manager had sent to the home office was not the right one and it was for EU nationals only. Also, the nursing-home manager, called Ms S., had a difficult working relation with the nursing-home owner. And I sensed that the manager was much stressed; still she did reassure me that she would do the correct form soon. A month went by and nothing happened. Later Ms S. was sacked from the job, and then all the work permit process got stopped. There was a regional manager called Ms M. who came to work

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<sup>84</sup> The policy for hiring overseas nurses is as follows: when there is a vacancy, the employer has to advertise locally first, then nationally and wait for a month. By the end of this time, if there is no local or national applicant available, then they can offer the position to an international candidate. They need to submit all the evidence of effort that was made to recruit local/ national candidate, for example job advertisements, to the Home Office with a correct application for work permit for their new employee. Then the Home Office, in theory, would issue a work permit. Finally, the nurse has to send her passport, work permit and employment contract, to the Home Office for a work permit to be placed in her passport.



there. After Ms M. joined the team, I asked her to help me with the work permit and Ms M. sent new sets of paperwork to the Home Office for me. By this time I did not have any valid visa; all the documents were already sent to the Home Office, waiting for a decision from the Home Office. I made further enquiries, phoned the Home Office again, and learnt that there were a couple more documents that were missing. They gave me two weeks to send all the missing but required papers. Later the Home Office suggested I go back to Nepal and apply for “*out-country work permit*”. It was very stressful and disappointing, but I wanted to do it all correctly, so I left Scotland straight away. After I arrived in Kathmandu, I received further documents needed for the work permit from Ms M. and I made the work permit application here, but it was refused again. I know many nurses, some of my own friends who were in exactly similar positions; they did not have to go through the same process and the stress. So, how the Home Office makes decisions is not clear.<sup>85</sup>

Another nurse who works in a nursing-home in Lothian region said:

I sent my passport and all relevant documents for the work permit visa. I did not hear from the Home Office for months, and I got very stressed and worried. A friend suggested to me to contact a solicitor and I did that. He dealt with my application and my visa was approved.<sup>86</sup>

She commented from her personal experience, that this inconsistent British immigration policy has created a business opportunity for private recruitment agencies as well as immigration lawyers. Some of her friends have had problems in obtaining the right type of work permit visa, as their employers did not fully know the procedure and the Home Office regulations. A nurse I met in Hastings had a job offer in a nursing-home in Wales but she did not receive a work permit. She had to leave the job after a month of working there, when her passport came back from the Home Office with the refusal for the work permit to be transferred into her passport. She then she had to go back to Nepal. Another nurse I interviewed in Scotland suffered very similar problems. Because of their fear of work permit refusal by the Home Office, some nurses have been extending their student visas just to remain in the country. At the time they were fully registered nurses with their NMC-PIN, and were eligible to work in the UK, but were working part-time, despite being desperate for full-time nursing posts. Nurses however, are here to stay and to shape their future and they do so by whatever means they can.

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<sup>85</sup> Interviewed on 12<sup>th</sup> of October, Kathmandu Nepal.

<sup>86</sup> Interviewed on 12<sup>th</sup> of June 2008, Edinburgh.

### *Adaptation to ever changing and new visa regulations*

In Chapter Four, we saw that not all nurses choose professional routes. Some come to the UK as dependant wives or as higher education students, depending on whichever visa is easiest to obtain. Two nurses might have come through two different channels with two different types of entry visa, but I have found that they usually have similar intentions to work as nurses. Because of their visa status, however, they can have quite different settling-in experiences. In general, nurses who have used IEC agents and have arrived in the UK as pre-adaptation or NVQ students, seem to get the worst deal. Many nurses who fall into this category have gone through a comparatively much more difficult time than those with work permits, or who arrived as dependant wives or as higher education students.

The story in Chapter Four of the two young Nepali men on student visas who went home from Aberdeen to marry, having asked their families to find them a “nurse bride” is, as we noted, not an uncommon one (Shakya 2009; Ghimire 2007). A year later in January 2009 this number had increased and there were seven or eight Nepali nurses living and working there on dependant wives’ visas while their husbands were undertaking a university degree. Nurses who joined their husbands in Britain tend to be fully supported, at least initially, during their early settling-in period. As these nurses hold dependant visas, they have more and better job options, and they can even work in the NHS. They therefore have more options and opportunities, as their employers do not need to get them a work permit.

Those who came to do masters degrees and for other further education joined their courses straight away, so they also had quite different arrival experiences. I have interviewed only one nurse who came to do a MSc. but stayed longer. I have been told by several informants that there are many nurses who came to Britain for further studies. For this set of nurses, the transition experience is very different from that of those who came to the UK directly to work as nurses. The nurse I interviewed had a full scholarship to do a Masters degree, with all accommodation arrangements already made. After arrival, she started the university term and had plenty of time to go through the NMC PIN and job-seeking processes. She also had less financial pressure because she had a grant for her course.

### **C. Support and facilitation networks in Britain**

After nurses arrive, support and facilitation networks in Britain play a vital role in the nurses' professional and social assimilation process. Friends and family, migration agents and recently developed professional links, are the main support networks and the major social capital. Those who do not have personal access to professional links and family members in Britain seem to have relied on migration agents for finding accommodation and a job, and then dealing with work permit issues. Their settling-in experiences are different from those who have close family or other support networks. For a start, those who have relied heavily on agents have paid large agency fees but, despite this, many had job or adaptation placements arranged only after they arrived in the UK. For these nurses it has taken a longer time to settle. Those who had access to professional links, for example those who came to Hastings with pre-planned adaptation courses, had their visa and work permits arranged by their employer. There are some nurses who have used multiple facilitation networks migration agents as well as support networks of family and friends.

#### *Professional Links*

I consider the link between Innovative Forum in Kathmandu and Mrs. Tuka Chhetri-Sandwell in Hastings, England as a 'professional link'. As we saw, this link was developed by Nepali nurses to facilitate nurses' migration from Nepal. Only a small number of nurses have had access to this link, but those who have used this link had direct contact with Mrs. Tuka Chhetri-Sandwell, their future employer and their adaptation training facilitators. Everything required to settle in Britain was organised by her and the Innovative Forum in Kathmandu. In total, Mrs Tuka Chhetri-Sandwell has trained 78 Nepali nurses. Some of them came via the Innovative Forum and others have contacted her directly, with a small number contacting her from other countries where they were working.<sup>87</sup> Those who had established this link, as already noted, had a much smoother and easier transition. Namrata, whose story I told in Chapter Four, was a good example of this and her arrival and survival experience was very positive.

I arrived here on the first of July 2005. I was picked up by a taxi from the Airport. And there was really a good welcome from Nepali nurses- *Didi-Bahini* (older and younger

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<sup>87</sup> I met and interviewed four nurses who had come to do their adaptation in Hastings. Three of them used Innovative Forum in Nepal and one came directly from Brunei.

sisters) who were already here. There was a hostel facility and I stayed there. Tuka Madam helped me to register for a National Insurance Number and to get all official documents ready. My accommodation [in Hastings] was all arranged, Tuka Madam gave me a day to rest. I started working and adaptation training the day after I arrived. I shared a house with a few other Nepali nurses. They had organised a welcome programme for me, and I felt very comfortable and welcomed. I spent a full five months for the adaptation training and two weeks after I officially completed the training I received my NMC PIN. I paid a total of £1000 fee for the adaptation course.<sup>88</sup>

Another Nepali nurse came to the UK after working in Brunei for several years. She conducted all her communication with Mrs. Tuka Chhetri-Sandwell from Brunei and managed to secure an adaptation placement in Hastings. She said:

I contacted Tuka Madam from Brunei while I was working there. As I felt I was a little familiar with nursing outside Nepal, I kind of expected what it would be like. I seemed fairly qualified and with plenty of work experience in Nepal and outside Nepal, they gave me a place to do an adaptation. I came here and went straight to Hastings. I had no problem. I started the adaptation training a few days after I arrived. It took me a full three months to achieve what a qualified nurse is supposed to achieve, but I was in Hastings for five months in total. It took me a while to get the NMC PIN. After I received my PIN, I applied for a job in London. It has been fairly smooth. I got this job in a private nursing-home in London and I am working there now as a qualified nurse.<sup>89</sup>

I met others who came directly from Nepal, and they also said that, when they arrived in Hastings, they were provided with accommodation facilities, usually in a house with a few other Nepali nurses. This professional link seems to be the most straightforward way to come to Britain but had only limited capacity. When I met Mrs Tuka Chhetri-Sandwell in Spring 2008, she told me that she could train only two nurses at a time and needed at least six months for one group.

#### *Facilitation or exploitation by International Educational Consultancy agents?*

Eva, a Nepali nurse, travelled to the UK with her friends. She left her two young children and husband back in Nepal. After arriving in Britain she had hoped to do adaptation training, and secure NMC registration and then find a nursing job as soon as possible. When she was preparing to travel to the UK, she had applied for an adaptation student visa in 2005 in Kathmandu but it was refused. Trying again, she was advised by an agent that she would not get a work permit visa or adaptation student visa, and was falsely informed that British visa regulations had changed in 2004. She was guided by this agent to apply for NVQ level three student visa this

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<sup>88</sup> Interviewed on 28<sup>th</sup> of February 2008, Hastings, England.

<sup>89</sup> Interviewed on 15<sup>th</sup> of March 2007, Wembley, London.

time. She followed the agent's advice and obtained this type of visa. Her main intention, however, was to undertake an adaptation training, (not NVQ level 3 training), and which she was willing to do anywhere, in the NHS or privately, and as quickly as possible. She had hoped to settle quickly and invite her husband and children over soon afterwards. When I met her in London, she was undertaking the ONP. She shared her early arrival and initial adjustment experiences with me:

Yes, we [herself and her two friends] arrived here on the 15<sup>th</sup> of September 2006; we arrived here early in the morning, somebody had come to meet us at the airport. The agent in Kathmandu had told us that they would put us in a hostel. We were prepared for that. From Heathrow, we went to Neasden in London, we were taken there by an agent but when we arrived there, it was not a hostel. The house we were taken to was very small and very dirty and very congested. I was with two other friends; they did not like to stay there either, because it was very dirty and congested for them too. There were a few Nepali already in that house, one nurse *bahini* (younger sister) and others who also had just arrived the night before, and someone else there. We found somewhere to put our bags down in their room. There was only one room, we refused to stay there and accept that room for three of us. The agents took us somewhere behind Neasden looking for other accommodation. We found a room, it was again fairly small, but with an attached kitchen and toilet but they wanted to put three people in one room and charge £65 a week per person. We did not want to pay so much, so we came back to the first place. It was getting late, we had nowhere else to stay that night, so we had to stay there with our Nepali nurse *bahini*. We spent a night there... although the agent did not want us to stay there [in somebody else's room], we just had to adjust in their one room, no choice. Next day we went to Aldershot to look for our friends. We stayed with friends in turns, one night with one friend and moved the next night to some other friends and some relatives, but we could not do that for long. We then found a place in Southall and moved here. Our friends helped us to find a room in Southall, my brother-in-law (*jwain*) helped us to find a place. So we moved here. It took us about two weeks just to find somewhere to stay.<sup>90</sup>

Another nurse named Sara had an adaptation student visa. She had paid her IEC agent £5000 in Nepal, all up front, for finding accommodation for her as well as an adaptation placement after her arrival in the UK. She had totally relied on a broker and had a very unsettling early experience. When I met her in a small village, near Bicester in Buckinghamshire in 2007, she had lived in various parts of Britain over the previous year, going through many difficulties and finally was under adaptation training in a nursing-home there. Her initial accommodation in London was arranged by the IEC agent but it was also very cramped and in poor condition, and she felt cheated. As she phrased it:

...It seemed OK initially, but trouble started once we went back to London. BP Khanal [the agent] had not arranged any accommodation for us but we were told that

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<sup>90</sup> Interview on 8<sup>th</sup> of April 2008 Southall, London.

everything would be done for us. We were taken to an Indian's house. We were kept in a waiting-room, in a very strange house. The landlord did not have any room to rent out, but BP Khanal kept us in a waiting-room, while he went to negotiate with the landlord privately in a different room. Later they gave us a room with a single bed for two of us to share. The room was very "*transparent*", "*glass*" window with no "*curtain*". Many males were living in that house in small rooms and no *curtain*, just two of us female. We were very scared. It was just so bad.<sup>91</sup>

A few days after their arrival, Sara was sent to Ireland with some other Nepali nurses by her agent, for an initial three months of English language training. About five weeks later, she was asked to come back to London, as the language course fee was too expensive. She was told by the agent that no adaptation training was available in Ireland, and he was trying hard to arrange a placement for her in London. She came back with a friend. Once again there was no proper accommodation arranged for them when they arrived. They had to share a room in a house, but were assured that it was only temporary. She said that she could not believe that people in London lived like that, in such poor conditions. As there was no adaptation training arranged for them, this temporary measure was extended for many weeks, with no job. The money they had brought with them from Nepal was about to run out, and the future seemed unknown. She was extremely stressed.

How can one live like that with so much stress, no job, no money and no support, I nearly *cracked*.

Another nurse, Kripa used an agent in Kathmandu to help her firstly with a British visa, and then expected this agent to find her a job after arrival in the UK. She had applied for a visa to do NVQ level 3, as per the advice from an educational consultant in Kathmandu. She was told that this course would take between 8 to 12 months. She was given an 18-months student visa. The agent had also told her that somebody would pick her up from Heathrow Airport and take her to pre-booked accommodation in London. Before she left Nepal, she paid the agent £370 as a month's rent and another £50 for somebody to take her to the accommodation. She said that she had arrived in Heathrow at around 7 in the morning with Gulf Air but, when she walked out, there was nobody there to meet her. She had no choice, she said, but to wait hoping that somebody would come and take her to the new accommodation. But no one came. Eventually she rang the contact person in London, but she experienced difficulty even making this first phone call. Everything was completely alien to her.

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<sup>91</sup> Interviewed on 28<sup>th</sup> of February 2007, rural Buckinghamshire, England.

To start with she did not have the right kind of money, but she managed to get some change. She put the coins in the phone box, then something happened with the phone, and she needed more coins. She could not even contact the person she wanted to contact, and did not get the coins back either. Then she had to go upstairs to find somebody at the help desk. Finally she managed to contact another agent in London but he told her that it was Sunday, and that he would not even send her a taxi and, with no accommodation ready for her, she should stay with a friend for a few days. She was very ‘stressed-out’:

...fortunately I had a friend’s contact number, so I rang her. This friend sent me a taxi to the airport to take me to her place in East London. I arrived there by two that afternoon. I stayed there for a few days, but I had to move out as there was not enough room for so many people. Later I contacted the agent again. The accommodation they arranged for me was very expensive. Another friend of mine was living in the Wembley area. I went and stayed there for about two weeks. While I was there, I started looking for a job or adaptation placement, or anything. Luckily, I found this place in Hastings, I spoke with the matron of this nursing-home, and the matron said that she could put me on a waiting list for adaptation, but in the meantime I could start working as a carer. I lost a month’s rent that I had paid to the agent in Kathmandu. I got nothing back, not even a cup of tea.<sup>92</sup>

After almost a month of restlessness in London, moving from one friends’ place to another, continuously searching for an adaptation placement, Kripa then went to Hastings for an interview. She said:

I found a job placement in Hastings. I spoke with the Matron of this nursing-home, and the Matron said that she can put me on a waiting-list for adaptation. But in the meantime I can start working as a carer. When I went to Hastings for an interview, I had also applied for CRB checks and was told that the process may take up to two months. I prepared myself to wait for the CRB report [she was told that it could take up to two months for CRB clearance]. A few days later, I was contacted by the Matron, if I wanted to start working I could do so, but starting with a few hours a week. I was delighted that I got something; initially I worked for about four-hours a day and some weeks only eight hours a week in total, like this. Fortunately, there became a space available for me to start adaptation early, and I completed adaptation in February

According to the current employment regulations in the UK, anybody who works with the elderly, children and vulnerable people needs to have been checked by the Criminal Record Bureau (CRB) and the record should be clear.<sup>93</sup> It appears that not all employers follow these government regulations. Before starting working in private nursing-homes, some nurses have had CRB checks and some have not. Further

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<sup>92</sup> Interviewed on 15<sup>th</sup> of March 2008, Wembley, London.

<sup>93</sup> CRB clearance is a police check. Applicants’ past criminal records are checked by police and reported to an employer, with a copy is sent to an employee.

inconsistencies with employment regulations were mentioned by nurses. Some were asked to wait for CRB clearance first, after their arrival in Britain, which does not seem to have happened with the Innovative Forum and Mrs. Tuka Chhetri-Sandwell's link. The CRB check normally takes between 4-6 weeks. It is not clear when and why some nurses needed CRB clearance and others did not before starting work. One explanation might be that CRB clearance prior to starting work seems to depend on how urgently a nurse's work is needed by her employer.

Nurses I interviewed had very little understanding of the employment regulations and UK government policy on working hours and working terms and conditions. Kripa's experience illustrates how private sector employers manipulate the system.

As highlighted previously, the number of overseas nurses waiting for adaptation training placements started to rise, and finding them became difficult, even for an agent. Nurses started to become more proactive. Hema, who I met in East Sussex, who had arrived to Britain in 2004, told me that she and a few friends decided to rent a room in London right next to where their agent lived. This was deliberately done in order to see the agent and nag him everyday to help them find adaptation training placements.

News and rumours circulate fast, so some nurses, who came to the UK via an agency with an NVQ student visa, learned quickly that nurses in Hastings had better luck than some others in London. Some of them moved to Hastings within a few days of their arrival in London, despite making no arrangements with Mrs. Tuka Chhetri-Sandwell. They felt that Hastings had a bigger Nepali community and a better support network, through which they thought it would be better for them to achieve their goals. I met several nurses who took this route.

Moti had used an agent to get an NVQ student visa to come to Britain, and later went to Hastings in search of an adaptation placement. She came to England in 2006, on her own, leaving her husband behind in Nepal. When I met her in Hastings in March 2008, her husband had arrived just a few weeks ago from Nepal. I was invited to join them for lunch in their flat. She had just returned from her night-shift in a nursing-home. Although she looked very tired, she wanted to stay awake and have lunch together and talk before she went to bed. We cooked lunch together and chatted. Over



our lunch she shared her experiences of becoming a nurse, of arriving and surviving in Britain. She said:

After I landed here, the first difficulty was to find a place to stay, and sort out the adaptation training. Finding a place for adaptation has been the hardest of all, but life has not been easy even after I received NMC PIN. With so much stress I completed the adaptation training and received my PIN. Then my next challenge came, I started looking for a full-time RGN post. But this has been very difficult. It is like... I go through one set of troubles, feel a bit happier and start seeing a light towards the end of a long tunnel but that disappears quickly and another set of problems arrive.

First problem was I could not find a place to be an adaptation student. I was already here as a [NVQ level-3] student. Then there was the change of NMC and ONP policy [regarding registration for overseas trained nurses] and I got caught by it; it got more difficult for us. Before, many nurses did not need an IELTS, now we need to obtain 7 score, it is very difficult to get. I struggled through that, worked hard and got the required score, then I had to face the entire problem with adaptation and PIN, I struggled through this again, told myself to be brave, worked through the difficult times and got my PIN. Now getting a job has become another hurdle. I went to so many interviews; in all four countries in the UK, every time I was told that I did well in the interview but never got a job. I have got my PIN, it has been almost a year now, and I still have to work as a carer. I have no idea why I don't get a job, but now people are very reluctant to offer a job to a foreigner who needs a work permit. Last time I went to Scotland for a job interview. I was offered a job in a nursing-home in rural Scotland; they have a new nursing-home just recently opened. I have been told that I can start working there whenever I am ready. I have resigned from my job here in Hastings and am hoping to move to Scotland soon, but let's wait and see. I would not be surprised if more troubles come ahead. It feels like I live in Hastings, I just go over one set of difficulties, and feel low and recover again, then the next set of difficulties arise.

I live in Hastings now, but I feel that there are more troubles coming towards me from London. There is no end to this chain of troubles. I have been here for almost two years. How long can I stay like this...? It feels like joining a chain of difficulties with no end to it (*"khilai sasakine samashyaharuko sikri"*). Troubles come one after another.<sup>94</sup>

A few months later Moti and her husband moved to Scotland from Hastings, taking all their belongings with them. She started working in a nursing-home in a small village near St. Andrews. Her husband started looking for a job or any further educational opportunity. I was in regular contact with them. Moti's new manager had applied for a work permit for her, which arrived in time. Later all the paperwork was forwarded to the Home Office for transfer of the work permit to her passport and the new dependant visa for her husband. She was working and waiting for the passport to come back from the Home Office. When their passports were returned they realised that the work permit visa was not granted. By then their visas had expired. She had

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<sup>94</sup> Interviewed on 1<sup>st</sup> of March 2008, in Hastings England.

the job and work permit, but why the Home Office had refused to give her a work permit visa was not clear to them, and there was no explanation for this. They went to the Home Office straight away, to Croydon, in London, in person, to find out the situation. There they were advised to go back to Nepal. Just before they left for Nepal she phoned me and told me:

...It has been a full two years I have been going through these types of tensions and stresses. We have gone through so much; waste of money and, time and so much mental torture to bear with it. After all this, now we have to go back home...<sup>95</sup>

In the summer of 2008, Moti and her husband went to Nepal, as advised by the Home Office, in order to change their visa status. They both felt extremely anxious and stressed about the whole process. They reapplied for the work permit from Nepal. They had to wait anxiously for almost two months there, and their future seemed very uncertain. Finally they were given a work permit and returned to Scotland in August 2008. It had indeed been an endless chain of troubles.

For a few other nurses, the whole migration experience has been very negative. A UK returnee nurse told me her story in Kathmandu in autumn 2008.

When I arrived in London early in the morning by night flight, I was met at the airport by my *jwain* [brother-in-law]. I went with him to Lewisham, where he lived. He shared a three bedroom flat with three other Nepali families. He had a room, and a shared kitchen and toilet/bathroom. It was a shock for me, I asked myself that “was I really in London or is it London?” A few days after I arrived, I contacted the Real Dream agent in London as I was facilitated by them in Kathmandu and had paid all agency fees up front. I was told that I would get something soon. A week went by and nothing happened. I contacted them again and I was reassured regularly that they were trying their best; all would happen soon, I would get a placement for adaptation course. I was waiting for this. My *jwain* was busy, working in a restaurant part-time and was a student as well. He did not have any time for me and there was nobody else to take me and show me around. I got used to spending days watching television and feeling restless. Every time I contacted the agents I would get the same reassurance from them. One month went by but nothing happened. I could no longer stay like that. I moved to Burnt Oak, to stay with my husband’s friend. From there, too, I contacted the agent regularly, but received the same old message. I met some other Nepali nurses in London, many of them were in the same situation, and I learnt that the documents I was given by the agents in Kathmandu about adaptation course at *Tudor College*, and placement at *Elizabeth Hospital* were all *fraud*. Some of the nurses in London phoned Tudor College and Elizabeth hospital but learnt that they were enrolled neither for any course nor for clinical placement for adaptation training. The agent said that they should not do the pre adaptation course because it was going to be very expensive but that they would get the adaptation course straight. I and some other nurses I met in London felt confused with this information, as we had visas to do the pre adaptation

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<sup>95</sup> Telephone conversation in April 2008

course. Yet, the agent insisted that they did not try it, because it would be too expensive, and if we really wanted to do it we would need to pay for it ourselves. But we thought that we had already paid for this in Nepal, that 5 Lakh rupees [approximately £4000-4500] covered it all. Another 4-5 months went by, nothing happened, I was missing my family in Nepal. No job, no adaptation there and I continued to stay with my friends for five more months in Burnt Oak, until February 2006”.<sup>96</sup>

Her difficult story in fact continues for some time. She lived in Britain for almost twenty months. In all that time she never felt settled, as she did not have a job and felt unsafe. The inappropriate visa gave her no sense of security. She finally returned to Nepal in March 2007.

From the NMC record of 527 fully licensed Nepali nurses in the UK, only 78 had access to appropriate professional and social support. The majority of nurses have been re-trained or professionally assimilated in private nursing-homes in the UK and have ended up working there afterwards. Despite this, nurses expressed that they ultimately want to work in the NHS, even though this is currently not possible, due to ethical recruitment regulation.

## Conclusion

In this chapter I have shown that, since the year 2000, Nepali nurses’ international migration to the UK has been increasing. How quickly and smoothly nurses go through their transition period is determined by *when* and *what entry routes and visas* nurses have used, and *what support networks* they have in Britain. Those who arrived before 2004, when the DH strengthened its guidelines for ethical recruitment of overseas healthcare professionals, had easier transitions than those who arrived after this time. But other factors, such as social and professional networks are equally important. Those who had professional links with the Innovative Forum and with Mrs Tuka Chhetri-Sandwell in Hastings, for example, were better received and supported through the process until they obtained their work permits. Those who arrived after 2004 relied increasingly on the proliferating number of IEC agents and had the worst of times at every stage in their initial settling-in process. A very small number of wives, who received a dependant visa, had a relatively easier transition.

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<sup>96</sup> Interviewed on 12<sup>th</sup> of October 2008, in Kathmandu Nepal.

Despite a greater need for more qualified nurses in the NHS in Britain, there is no easy way for Nepali nurses to secure NHS jobs. Arriving in Britain, and struggling with regulation, jobs and visas, has been tough for the majority of nurses. Smith et al. (2006) found that, in the context of international nurses' migration, those who were recruited by the NHS, and entered into the NHS in batches have better arrival and settling-in experiences. In 2000-2001, nurses from other countries, who were recruited directly by employers, had their work permit visas, adaptation programmes, accommodation facilities and other administrative procedures handled by their employers. They even had a "meet-and-greet" programme organised by their employers, and were given a start-up pack of food and telephone cards (RCN 2003). Unfortunately, Nepali nurses have not been members of such privileged groups, and there has been no such organised official nurse recruitment from Nepal.

We have also seen that the DH Code of Practice on International Recruitment of Healthcare Professionals, which was written to promote ethical practices, has failed. Instead it has created the space for the poorly-regulated private sector to exploit foreign nurses. These ethical guidelines are supposed to help poor countries like Nepal to retain their valuable resources. Yet it has been quite evident that, in Nepal, it has made no difference, as the country continues to be a prominent nurse-supplying country to the UK.

Looking back to Chapter Two, we have seen that women in Nepal are highly dependent on family and close support networks. When they arrive in Britain this support is absent, and they are easily prone to exploitation. A new culture of living and working has to be adjusted to rapidly. We have seen how migrant nurses have gone through and experienced the initial hurdles: the lack of support from their supervisors during their adaptation training; the poor standard of training guidelines; and the inconsistencies with employment policies, such as CRB checks. Despite difficulties, apart from a few who returned to Nepal, most nurses have made adjustments and adapted to their new professional and social lives. The next chapter will explore their working lives in detail and their sense of professional success and achievements during their time in the UK.



**Figure 6.1:** From *Kantipur Kosheli*, a Nepali national daily. The title reads “Nepali nurses in Britain”. This piece presents positive images of nurses who have secured nursing-home jobs in the UK (Pokhrel, 15 November, 2009).



**Figure 6.2:** From *Nepal*, a national weekly: The title reads “Pitiful situation of Nepali nurses in Britain”. Given the lack of proper nursing jobs, senior Nepali nurses end up working in restaurants, cooking and cleaning (Acharya, 22 October 2006).

## **CHAPTER SIX**

### **“THERE IS A VAST DIFFERENCE FROM WHAT I HAD THOUGHT”: WORKING IN THE UK**

In the last chapter, I discussed Nepali nurses' experience of their arrival and initial settling in the UK; how they obtain their NMC PIN and jobs. In this chapter I continue to explore their professional or working lives. I discuss the nature of nursing work; working conditions, and workload and nurses' relationships with their colleagues, managers, patients and patients' relatives. I begin this by presenting Sumi's story, as it touches on the main areas I have highlighted above.

#### **Sumi's experience: a case study**

I met Sumi for the first time in Scotland, in the summer of 2007, and I have remained in touch with her regularly since. She is a young, single woman in her late 20s, dynamic and talented, who came to the UK in December 2004, with a dream of becoming a Cardiac Care Nurse in a high-tech cardiac care unit (CCU).

After qualifying as a staff nurse in 2001, Sumi had applied for a CCU nursing post in Gangalal Heart Centre in Kathmandu, the country's most advanced heart care centre. Competition was so fierce that Sumi did not get the job. She was very disappointed but she continued to aim for a post within CCU nursing. Within a few months she was offered a staff nurse post in another of Kathmandu's private and modern teaching hospitals. She worked there as a surgical nurse first, then moved on to be a CCU / intensive care unit (ICU) nurse, and she also worked in various other departments in rotation for over three years. One of the main reasons she wanted to come to Britain was to fulfil her dream of obtaining cardiac care experience, in a technologically advanced healthcare system.

Her interest in moving to Britain stemmed from the time that her social and professional colleagues started to move to the UK around 2004. She too began to imagine her future opportunities in the UK. She met no major family resistance, nor had she any commitments that would have prevented her from moving to the UK. Indeed her parents, brothers and sisters fully supported her desire to move. She made the necessary preparations and arranged an adaptation placement through a friend

who was already working in the UK. With her friend's help she found a training place and paid £4,500 in total, as adaptation training fees: £1000 as a deposit in Nepal before making a visa application to travel to the UK, and the remaining £3500 before she started her training. She felt that she was lucky, as her friend was already in the UK and found her a training place without much difficulty, though it was costly. She managed to overcome all the common hurdles, already described in Chapter Four, with the visa process in Nepal, and many initial challenges with adaptation placements and NMC registration in the UK, similar to those discussed in Chapter Five. She finally received her Professional Identification Number (PIN) in December 2005.

She felt that working in the nursing-home, where she did her adaptation training, was a completely 'multicultural' experience, as it was staffed almost exclusively by an overseas workforce, with nurses from the Philippines, India and Pakistan. The nursing-home owner was from Pakistan and the manager was Sri Lankan and she commented that it did not feel as if she was in Britain at all. Further, she was not professionally stimulated during this period, as she found nursing-home work slow and very basic, with no new nursing skills to learn and practise. Sumi felt that she was actually deskilling herself, moving further and further away from CCU/ ICU nursing. One year in a nursing-home was long enough for her. In this time she lost her professional confidence even to work as a general nurse in an acute hospital clinical setting, quite apart from CCU or ICU work. She realised that there was no chance for her to learn advanced nursing skills, let alone use any of the simple nursing procedures she was used to in her last job in Nepal. She decided to look for a new job: one that would ideally lead her towards specialisation in Cardiac Care Nursing.

After receiving her NMC-PIN, she started looking for a full-time staff nurse post, preferably in a CCU. She made some enquiries about CCU jobs but learned that all CCU posts were attached to NHS hospitals, and she was not eligible for one. In desperation, she moved to Birmingham where she had a close friend, who was also a nurse from Nepal. She stayed with her friend and while in Birmingham she continued to look for a job. She said:

...here [in Scotland], my *daju* [elder cousin's brother] was here in the university. And I decided to leave there [Eastbourne], but I did not know where to go and where to



start from. I thought it would be better, and easier to be near somebody I know. My friend, who just phoned me [she received a phone call during this interview], and she wanted me to go to Birmingham. I went there for a week. I did not look for work there, but I stayed in her place. I did not like the area very much. News [of Birmingham] was then very negative at that time. I heard about racial tension and fights. I did not apply for any job there. While I was there I asked my *daju* to find me some contact telephone numbers of some nursing-homes from the Yellow Pages. He gave me a few numbers, and then I rang some nursing-homes. One nursing-home said “come and work from next day”. I said “I am not in Scotland now, I am in Birmingham now, so I can’t come tomorrow but I can come the day after tomorrow”. Next day, I booked my ticket to Scotland, and then started working the day after that. Forget about the interview, they did not even have time for any paperwork, no work permit, nothing. They were so desperate I started working next day. And also, people here were not aware that nurses from overseas nurses require a work permit to work here. They took it like they were employing a British citizen; they employed me like I was local.

Sumi was disappointed not to have been able to work in a CCU, but she accepted the fact that she did not have much flexibility and choice with what kind of job she wanted and where. She found that she would need to wait for a further five years to secure “Permanent Residency” status first, and only then would she be allowed to enter the NHS. She prepared herself to wait for this, as there was no other alternative quick or easy route to fulfil her dream. She had to accept the circumstances and decided to apply for any nursing-home job she could find: at the time any job seemed better than no job. Although this nursing-home was in a small village, it was within commutable distance from the city centre where she was living, and there were regular bus services, and she could live near her relatives. So, after a period of unsettling experiences in the South-East of England, she finally moved to Scotland in the summer of 2006.

Sumi got her first nursing-home position very easily without even a proper interview process; but she told me she then faced difficulty in sorting out her work permit. She did not know much about the work permit regulations and application process and her nursing-home manager was not fully aware of this either. The process was delayed, but she had already started working there. She knew that she would need a work permit to work legally, but all this was in her manager’s hands and she could do little about it, which compounded her stress levels.

After being there for a while she felt that the nursing-home manager was not very supportive; was maybe racist and a bully. Sumi felt that she was harassed excessively. It became unbearable and she started looking for an alternative job. Some of her work



colleagues were also bullies. She felt very lonely and vulnerable. At one stage she contacted the Royal College of Nursing (RCN), the nurses' trade union body for help. An RCN representative visited her work place and spoke with the manager and other work colleagues:

Yes, she [manager] said she is a very good staff member and she is a very reliable staff member, etc. What could the RCN staff say? Nothing! She appeared very nice. Who would they believe, what could they say? They first said "*RCN will not tolerate any racism at all, we will do some action*" but when they visited they did not find any problem.

She continued

...they [the manager and some of her colleagues] called me friend and in front of the RCN representative, they praised me for how hard I worked and for being a good team player and a good colleague, etc.

It seemed like there was nothing to investigate so the RCN representative left with no action. But the day after the representative's visit, everything went back to the way it was before, and Sumi decided there was no point in staying there. She felt it would be better and healthier for her to be elsewhere. The following conversation illustrates this:

Sumi: This is my feeling anyway. I felt that I was harassed.

Radha: Can you give me some examples of how you were harassed? You mentioned you felt that you were picked on more than other staff... anything else?

Sumi: For example, we all are working hard and we always have staff shortages, staffing is a common problem, in some shifts we were like supposed to have six staff but, only two come on duty, it could get this bad [staff present], and we [as a registered nurse and the shift in-charge] have to deal with everything.

Radha: Why only two, because of people off sick or just no staff in the rota?

Sumi: Off sick, or they just report off sick. When you work under a stressful environment, of course you miss out some work, we all do. When some colleagues miss some work, it is OK. But when I miss out something, she [the manager] would pick on me, only me. Some colleagues noticed this too and they asked why is it always you that gets picked on? It was like nit picking, I felt I was picked on excessively, so [she had just] decided to leave that place. This is the main reason [for leaving the work].

While working in the nursing-home, she continued to hold on to her desire to get back to Cardiac Care Nursing, but she felt that she really had no real choice but to wait for another couple of years. Sometimes she said "it felt like too long to wait and, at other

times, so close to getting PR [permanent residency]”, and thus reaching her goal. While working in this nursing-home, she thought she should at least learn a bit about NHS work and gain some experience in her own spare time. At one point she became very impatient, so just decided to do a bit of NHS nurse-bank work in her days off. Accordingly she joined the NHS nurse-bank, as a step into the NHS and also to find out about the system. This was possible as she now had a work permit for the nursing-home, and, with this permit, was able to work part-time in the NHS. She had an induction day for bank nursing and started working one day a week, and in some weeks just a few hours, during her days off. She said she was happy that she had started working in the NHS, but at the same time found it very hard to adjust to the new working environment. She felt the staff were not very supportive; some were even racist and she experienced harassment there too. The ward in which she worked was just another long-term elderly care unit. Work was thus very similar to her everyday nursing-home work, not at all like working in CCU. She tried it for a few months, but got to a point that it was emotionally draining, with little feeling of achievement, and she stopped. Over a year had passed by this time.

Sumi still had a few years to wait for “Permanent Residency” status. She felt however that she should not waste her time but continue to try to find a stimulating job or a course. She started looking for a part-time university course that would perhaps direct her towards getting a CCU/ICU job. She made all the relevant internet searches, and found out that there was an “open day” in the University of Dundee that ran nursing and health science courses including Cardiac Care Nursing. She went there with much enthusiasm, met the Cardiac Care Nursing course organiser, and expressed her interest to enrol on to the training. She learned, however, that all Cardiac Care training courses are attached to clinical posts, and are intended for those who are already working in the field. She returned home with yet another disappointment.

Working in the nursing-home had never been a satisfying experience for her. It did not provide the work experience she wanted. She also felt that she could not have any social life with the people at work, the same people who would make stereotyped racist comments at work, such as “how can you stay so slim and eat curry every day?” She spent most of her days off on the internet chatting with family and friends in Nepal, or visiting her Nepali friends and relatives in the town she lived or watching

DVD films. She eventually found a nursing job, in a different nursing-home, very close to her rented flat in the city centre, and started working there. It was at this time I met her for the first time, at our interview in Summer 2007. I met with her several times and I remain in touch. As of July 2010, she is still keen on a CCU position and is waiting for “Permanent Residency” and the opportunities that will come after that has been achieved.

Many younger nurses I met dreamt, like Sumi, of furthering their professional careers, but until they have been granted “Permanent Residency” status the majority have no professional choices. This is not just the experience of Nepali nurses’ either. Overseas nurses, those who come to the UK from outside the EU countries and need visa and work permits, have to endure similar situations. Eventually they become not only deskilled but de-motivated about looking for career progression opportunities (Larsen 2007). Lack of job choices, racial discrimination and bullying and harassment at work are all too common and this experience is shared by many overseas nurses globally (Dicicco-Bloom 2004). I will examine these situations in detail, starting with nurses’ working conditions.

#### **A. Nurses’ working condition and working life**

I traced the qualifications and the experiences of the nurses I interviewed. The table below illustrates nurses’ professional mobility. It looks first at their professional qualification in Nepal and where they were on a career ladder, and then at the point where they joined the professional career ladder on arrival in the UK, and where they were professionally in Britain at the time of the research interviews.

**Table 6.1: Nurses professional mobility before and after migration to the UK**

| <b>Respondents’ ID</b> | <b>Qualification in Nepal</b> | <b>Last job in Nepal</b>    | <b>First job in the UK</b> | <b>Job at the time of interview</b> |
|------------------------|-------------------------------|-----------------------------|----------------------------|-------------------------------------|
| 01                     | SN, BN, MEd                   | Manager in an INGO          | Carer                      | SN in a NH (night nurse)            |
| 02                     | SN                            | ICU/ CCU Nurse              | Carer                      | Carer in a NH                       |
| 03                     | SN, BN                        | SN in a government hospital | Carer                      | SN in a NH                          |
| 04                     | SN, BN                        | CCU nurse                   | Carer                      | Carer in a NH                       |
| 05                     | SN                            | School nurse                | Carer                      | Carer in a NH                       |

|    |                                       |   |  |                                 |
|----|---------------------------------------|---|--|---------------------------------|
| 06 | SN, BN, PG in Women's Studies and MEd | Various I/NGOs management positions and nursing in Brunei for 27 months     | Carer  | SN in a NH                      |
| 07 | SN, BN                                | Nurse Lecturer, Reproductive Health Co-ordinator for a USAID funded project | Carer  | SN in a NH                      |
| 08 | SN, BN                                | Nurse Lecturer  | Carer  | Carer/ ONP student              |
| 09 | SN, specialist CCU nurse              | CCU/ICU nurse in a major teaching hospital in Kathmandu                     | Carer  | SN (night) in a NH              |
| 10 | SN                                    | Maternity nurse (Govt position)   | Carer  | SN in NH                        |
| 11 | SN                                    | CCU/ ICU and surgical nurse   | Carer  | SN in rural NH                  |
| 12 | SN                                    | Orthopaedic nurse   | Carer  | SN in NH                        |
| 13 | SN                                    | Orthopaedic nurse   | Carer  | Carer in NHS Hospital           |
| 14 | SN, BPH, MSc in Public Health         | Management position in an INGO  | Carer- but came to Britain as an MSc student | SN in a NH                      |
| 15 | SN, BN, MPH                           | Management position in an INGO  | Carer  | SN in a NH                      |
| 16 | SN                                    | Theatre / Surgical nurse  | Carer  | SN in a NH                      |
| 17 | SN, BN                                | Family Health nurse   | Carer  | SN in a NH                      |
| 18 | SN                                    | Eye specialist nurse  | Carer  | SN in an NHS eye clinic         |
| 19 | SN                                    | Maternity nurse   | Carer  | Carer in a NH (but had NMC PIN) |
| 20 | SN, specialist maternity trained      | Birthing Centre nurse with specialist maternity training                    | Carer  | Carer in a NH (but had NMC PIN) |
| 21 | SN, BN                                | Theatre nurse in a major teaching Hospital in Kathmandu                     | Carer  | SN (night) in a NH              |

ONP= Overseas Nurses Programme; NH= nursing-home; SN= staff nurse

### *Type of nursing and workplace*

The table above illustrates that the majority of Nepali nurses had had further education in Nepal after their initial staff nurse (SN) training; some even had achieved masters' level education in Nepal. However, when they arrived in Britain, all but two

had to start their professional career as carers in a privately-run nursing-home. For them the easiest entry point, or the only option available, was this kind of post. The two nurses, who did not need work permits, because they had dependants' visas, were working in NHS hospitals. Nurses informed me that they were told by their agents in Nepal that they would get nursing-home jobs easily. Unfortunately nurses had based their understanding about the nature of private nursing-home work on what nursing-homes work in Nepal was like. They travelled to the UK with inappropriate expectations.

### *Nursing-home care work: a culture shock*

Almost all the nurses I interviewed said that they had heard (from the IEC agents in Nepal) that they would easily get some care-work in a care-home, or in a nursing-home, but they did not realise the nature of work it involved. In Nepal, there is little or no understanding about the nature of nursing work in the UK.<sup>97</sup> Nurses said that, before coming to the UK, they had neither seen nor looked after patients who were so dependent on carers and nursing staff, for all their daily health and personal care needs, on such a long-term basis. Many nurses, when exposed to nursing-homes for the first time in the UK, had a big "shock". Below, I present some nurses' experience of work-related culture shock.

Kiran (whom I introduced in Chapter Four) came to Britain with over ten years of work experience and a BN degree from Nepal. She arrived in Britain in July 2005. In Nepal she had worked in a "British-style" healthcare system, run by the British authorities for the Gurkhas. She revealed:

We used to get the Nursing Standard, Nursing Times and Nursing Research Journals. I used to read through them every month to update new research evidence in nursing. My main job there was to work as what would be equivalent to a Health Visitor here in Britain. I kept up all immunisation records, managed hypertension and diabetes, chronic wounds etc. I thought that nursing in Britain would be like that and from what I read in the Nursing Standard that it would be more innovative and evidence-based. But when I first went to my very first nursing-home, I was totally shocked, shocked by the fact that I saw very thin and malnourished elderly woman, and in the same place, extremely overweight and totally dependent woman. I had never seen and used any kind of hoists or moving aids to transfer totally dependent patients before I came here. I

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<sup>97</sup> Nursing-homes and residential care-homes in the UK provide personal and nursing care to elderly and disabled people. Generally people come to these institutions for long-term care, and it is not often that they get better and go home. For many overseas nurses this is a totally new social phenomenon (RCN 2005).

felt like crying, I did not know how I would be able to handle this, how I could work there. My expectations were 90% wrong.<sup>98</sup>

A young private school educated and private college trained nurse Suruchi, who came to Britain in 2005, shared her experience:

I went into nursing because I wanted to go abroad. From Nepal, it [nursing] seemed like the easiest route to get any opportunity abroad. I was trained in one of the private colleges in Pokhara, attached to a big modern private hospital under the management of the Manipal group. I was not sure about the nursing work in a practical sense, but I really liked teaching, and I wanted to be a nurse teacher. After I was qualified, I got a job with an NGO [non-governmental organisation]. My parents owned and ran an English boarding school and I worked there for a while as a school nurse. I then came to Britain to do NVQ level-4. My expectation of healthcare and nursing was that it would be very technologically advanced and modern, with nurses using all modern technology, but I came to this nursing-home in rural England, and there was no need for any modern technology. It was all physical care. We ended up doing BBC - British Bottom Care.<sup>99</sup>

Another nurse, Sabita I met in Scotland said:

I did not know much about elderly care. I thought that we would get a job in an acute sector hospital as this is what we did in Nepal.<sup>100</sup>

The nature of nursing-home work or residential care had been completely misunderstood by almost all the nurses I met and interviewed, and they had very different and unrealistic expectations. Maya said:

I did not know and understand the meaning of 'residential-home'. When I received a letter that said I was to work in a nursing and residential home, I asked both the agent who arranged the work and my friend who was already working in a residential-home for a further explanation. It was then explained by my Nepali friend that residential-homes are where people live, get looked after and fed, etc. When I started working there I found it more like a Hotel. I was supposed to be doing my adaptation training, but I was learning to set out the dinner trolley, offer and collect menus; serve food and feed elderly people, amongst many other things. It felt as if I was doing hotel management training, not learning any clinical nursing at all.<sup>101</sup>

The above nurse worked in Nepal's oldest state-funded and, for Nepal, relatively the most high-tech maternity hospital in Kathmandu, providing maternity services. She told me that she had extra training on how to manage maternity emergencies. She was

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<sup>98</sup> Interviewed on 28<sup>th</sup> of February 2008, in Hastings, England.

<sup>99</sup> Interview on 1<sup>st</sup> of March 2007, in rural Oxfordshire. The first time I heard the expression 'BBC' or British Bottom Care, was from a Nepali Nurse, but this expression was widely used by migrant nurses from other countries, mainly those who work in private nursing-homes (Allan and Larsen 2003; Smith *et al.* 2006)

<sup>100</sup> Interviewed on 21<sup>st</sup> of June 2007 in Scotland.

<sup>101</sup> Interviewed on 17<sup>th</sup> of May 2007, rural Northumberland.

used to dealing with post-partum emergencies, setting up and giving intravenous fluid infusions and even giving emergency drugs. In her new nursing-home in Britain, however, she had to learn to take food orders and set up dinner tables. She thought that it was hardly necessary to be a trained nurse and experienced midwife to do this new job. She is just one of many, as can be seen in the table above. Nurses had worked in the most technologically sophisticated areas like CCU and others were in programme management level, before migrating to the UK. This is what they expected to do in the UK. As Parvina said:

I thought nursing in the UK would be like the nursing we have observed and practised in Nepal, but only advanced [of a higher standard and more technologically sophisticated]. I did not know anything about care of the elderly.<sup>102</sup>

This misunderstanding comes from Nepali nurses' lack of exposure to this type of work before they arrived in the UK. As noted earlier, in Nepal, there are no nursing-homes for long-term care and care of the elderly. Elderly people, and people who need long-term care, are looked after at home by their extended family members and relatives. As already highlighted in Chapter Two, most Nepali house-holds are composed of a joint family; sons and daughters-in-law, and grandchildren provide all support for their elderly relatives. Modern technology and advances in healthcare, which help and support elderly and disabled people to live longer in western countries, are simply non-existent in Nepal. People there die of common illnesses and treatable conditions such as infections, so national health priorities and healthcare training focuses are very different.

Although private nursing-homes have been operating since the late 1980s in Nepal, these are mainly in bigger urban centres like Kathmandu, Pokhara, Biratnagar, and Bhairahawa, but are not for care of the elderly. The services these nursing-homes offer are very similar to the clinical services in private-hospitals in Britain. Nepali nursing-homes cater for wealthy clients with acute healthcare needs, including most types of acute medical, surgical and obstetric and gynaecological conditions. Due to the different population demography and different national health priorities, nursing plays a very small role in the care of the elderly and the rehabilitation field compared to the British healthcare scene. In Nepal mainstream nursing is geared mainly towards

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<sup>102</sup> Interviewed on 21<sup>st</sup> of June 2007, rural Scotland.

tertiary care services provided in major hospitals. Additionally, until 2006-07, Nepali nurse education did not focus in any way, either theoretically or practically, on the care of the elderly. This is a completely new area of nursing for Nepal's trained nurses as already discussed in Chapter Three.

It can be seen that many Nepali nurses arrive in the UK with higher degrees and many years of experience, but their qualifications and experiences are not directly relevant to the nursing jobs available for them in nursing-homes. Not only do they have high qualifications and experience, they also have high expectations. Yet they end up working in nursing-homes. As Sumi explained above, they find the nature of long-term care for the elderly, and disabled people in general, very basic and slow in pace. It proves in essence to be deskilling. As Suruchi noted, nursing-home work can be described as the "BBC", and this is clearly one of the least desired aspects of nursing in Britain (Smith & Mackintosh 2007). When nurses had to speak about their work in the UK, they seemed shy and embarrassed: many were not keen to share any details of this with me. Some used alternative ways to describe their work in nursing-homes. For example, a Nepali carer I interviewed in Hastings told me that his role was to provide pastoral care to nursing-home residents, but that he would do many other things to help people "including feeding them and changing their clothes".

While still in Nepal, nurses seem to imagine nursing in the west as technologically advanced, as it is advertised in nursing journals as a glamorous job; quite the opposite to nursing-home work. Some nurses feel that care-home jobs are just like being a helper to people who require help with things like feeding, washing and brushing their hair. A senior nurse I interviewed in the summer of 2007 in Nepal (who sounded like a potential candidate for migration) said she wanted to verify some information with me:

I heard that nursing care jobs are easy in Britain, in America and in Australia. Patients there need help with having a shower, getting dressed and putting make-up on. Some women I heard want to have lipstick on, and help with food and sometimes with shopping etc. as they are lonely and don't live with their families, they need some companionship.<sup>103</sup>

Hema who I interviewed in Hastings said she had a big surprise when she went to a nursing-home for the first time to work:

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<sup>103</sup> Interview with a nurse lecturer in Kathmandu, summer 2008.



...Before coming here, my expectations were that I would get very good work in a big hospital, very busy, hard work - a luxurious place to work, with a good salary, all computerised, etc...

But when she started working in a nursing-home, she realised:

...I was in a small nursing-home. The care there was good but there was not enough opportunity to learn much about clinical nursing [not exposed to many clinical activities and nursing procedures]... I did not get clinical nursing experience, I did not get the chance to get exposure to many areas [of acute care nursing], and I did not even get the chance to learn about wound dressing...<sup>104</sup>

Care of the elderly or geriatric nursing is seen by many as 'basic care'. Melia has illustrated how even nursing students in Britain consider that this type of nursing is "not really nursing" but basic care (Melia 1987: 132-135). For many of these Nepali nurses, who do not share the same cultural background as the people they look after, it is not surprising that they consider this branch of long-term care nursing as being menial. Understandably for them too, it is not really nursing.

### *Workload*

Not only was the type of nursing a shock to them, but many nurses perceived that the workload in nursing homes was very heavy too, and many admitted that they were not used to this amount of work in Nepal. Kiran, who had expressed culture shock when she came to work in Hastings, noted:

...but when I arrived here, it was all about only pad round, basic wash, feeding people and putting them in bed. I found it completely different from what I had thought. What happened at first was the *didi* [older sister] I had lived with said one day, OK, come with me, I will take you to my nursing-home. In a nursing-home in Nepal, they have young adults and old people and children and all in general. Nepali nursing-homes are big and modern. But, here they are only for old people.... When I heard about looking after old people, I thought it would be old people like our old folks in Nepal, who can walk about and go to bed and get up all by themselves, but here it is very different. It is almost 90% different from what I had imagined. I thought that I would be working in a ward, and like that. There is a vast difference from what I had thought...<sup>105</sup>

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<sup>104</sup> Interviewed on 2<sup>nd</sup> of April 2008, in Hastings, England.

<sup>105</sup> Interviewed on 10<sup>th</sup> of February 2008, Hastings.

A nurse's husband in Aberdeen told me:

...my wife regularly cries after doing a long day in a nursing-home, she says it is too hard and too tiring, how long can she last like this. She tells me that nurses and carers have to deal with very dependent residents...<sup>106</sup>

Sumi, who works in Dundee said:

...usually we are always short of staff. Eh... staff patient ratio. It would look OK until somebody phones off sick. In the morning, there would be one or two registered nurses and the manager plus four carers; and in the evening one registered nurse and three carers for twenty-five to thirty residents. But regularly staff phone to report they are off sick. If all staffs came on duty, the staff-patient ratio would be OK. But... it's like that everywhere, when they feel, tired and get lazy and don't want to go to work they phone in sick, this is a common problem in a nursing-home. The rest of the staff will have an extra workload as there is nobody available to replace these sick. For example, it is like this as it depends on their mood...in a little while if I don't want to go to work, I too will phone them and tell them that I am not well... [She giggles] But I have never done this, myself.<sup>107</sup>

The example above reveals that if shortages of staff occur in the nursing-home, perhaps due to sickness, personnel are not replaced. Work is accordingly divided amongst the available staff there and then. Nursing-home work is already seen as heavy, but nurses regularly have to share this extra workload too. These practical issues are difficult to understand when nurses are still in Nepal. The nurses' experiences described above, particularly regarding the practical and everyday nature of nursing-home work and the workload, do not seem to be fed back to Nepal. When I asked Sara what she would share with her friends in Nepal, about her work environment and workload if they wanted to come to Britain, she replied:

I will tell all the truth about the nature of nursing care [referring to the nature of nursing and workload] in Britain to my friends. If they still want to come and do the job that is fine...at least they are informed about it.<sup>108</sup>

Sara had gone through a period of extreme frustration and disappointment, but at the time of interview was settled with a proper staff nurse post. Whether she will tell the whole story in Nepal is another issue, and one to which I return later in the chapter.

In summary, before migrating to the UK, Nepali nurses had neither training nor socio-cultural exposure to care of the elderly and long-term care settings, so their initial

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<sup>106</sup> Conversation with a nurse's husband June 2009, in Edinburgh.

<sup>107</sup> Interviewed 21<sup>st</sup> of June 2007 in Dundee, Scotland.

<sup>108</sup> Interviewed on 28<sup>th</sup> of February 2007, rural Buckinghamshire.

experiences were not positive or fulfilling. As time passes, however, nursing-home work in Britain becomes more normal and more acceptable for them. Like Sumi, nurses come to realise that there is no easy way for them to find their desired job and like it or not, many are compelled to accept nursing-home jobs. After coming to terms with this, most nurses seem to focus on getting as many working hours as possible, and earning as much money as they physically can. Their goal-posts are readjusted and their main achievement now becomes to save money at least. For those who have been separated from their families, family reunion becomes their next major goal. This will depend on the nurses' savings, so the availability of working hours and monthly earnings become very important. Despite the undesirable nature of nursing-home work and the heavy workload, many nurses are prepared to work for as many hours as they can.

#### *Working hours and money*

The majority of the nurses I interviewed were doing night shifts and work involving unsocial hours, and some were working in more than one place. I was told this is a necessity, in order to become financially viable in Britain, to recover from debt, and try to repay the money they had borrowed and invested, when making their move to the UK. Those who planned to bring their family to Britain needed to have a good bank balance and a regular monthly income, and their energy seemed to get diverted towards achieving these goals. When I asked about their achievements and successes, almost everybody said that their main achievements have been the number of working hours and the total amount they were able to earn each month. Many expressed the view that they get “good hours”, good hours being 60, 70 and sometimes even 80 hours a week. In every interview, the nurses' immediate responses were either yes; “*majjako hours painchha*” (one gets plenty of hours) or no “*hoursnai paidaina*” (one does not enough hours). The following conversation illustrates this:

Eva: I am happy here, *majjako hours painchha* [good or plenty of hours are available] and I have to be happy with this.

Radha: Then you were in Oxford. It was alright there you said, and there too you were getting “good hours”?

Eva: Yes, then in Oxford. It was OK. But we did not get paid so well there, as we were sent by the agency: they used to take money off from our hourly rate to pay the agency. We only received £5.35 an hour. Because this nursing-home had to pay the agency that

money came from our salary, we were told. They used to get commission from our salary too. Those who work more hours earn more and those who work fewer hours earn less... right from the start I have been very lucky I have not had any problem with getting *majjako hours* - good hours.<sup>109</sup>

Eva had left her husband and two children in Nepal. When I met her in London in summer 2007, she was trying hard to save up as much money as she could, so that she would be able to invite her family to join her. For many Nepali nurses, as with many other low-paid workers working long hours becomes more of a necessity than a choice, in order to increase their chances of family reunion.

Namrata informed me that she moved to the UK in July 2005. At the time of the interview she seemed quite settled. She said that initially she worked very hard - many hours a week, nights and double shifts - so that she could earn enough to repay the loan she took to move to the UK and also help her elderly mother in Nepal. When I met her in Hastings in spring 2008, she was working at night, and doing some long days too. She had her two children with her in Hastings, and reported that she was happy with her achievements so far.

Most nurses work extra hours purely to support their family and their husbands' or their children's education. One nurse who works in a nursing-home in a small village near Bath told me:

My son is at university here in England. I am paying for his overseas student's rate, which is around £10,000 a year. I have to work longer hours and extra days some week just to survive and pay his fees.<sup>110</sup>

Another nurse, who came to the UK in 2008 as a dependant wife, started to look for a job soon after she arrived. Her husband is a full international fee-paying student, and this costs them over £9000 a year. In order to repay the money they borrowed to make the initial investment for migration, she had to work longer hours every day. She said:

...the nursing-home does not pay any extra money for working unsocial hours or in the weekend. The rates are not very good so I have to work more hours. Some weeks I work 50 and 60 hours, usually 12 hours a day from 8 am to 8 pm. I have never worked

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<sup>109</sup> Interviewed on 8<sup>th</sup> of April 2007 Southall London. I had a telephone conversation with one of Eva's friends in spring 2009, and I was informed that Eva had been joined by her husband and their two children, and they were living in London.

<sup>110</sup> Telephone conversation with Sakun on 30<sup>th</sup> of May 2009, she lived in a small village near Bath, England.

like this before in Nepal, and I get very tired and I feel like crying. But I don't have much choice.<sup>111</sup>

Many nurses do not get unsocial hours allowances in private nursing-homes. They have to work many hours to survive and support their families in the UK. Some employers even produce fake documents for nurses to show the Home Office to get a work permit. Some even fake the salaries and other benefits. Maya received a job offer and a fake contract to work in a nursing-home in London. She informed me:

The manager at my new job in London has forwarded my work permit document which says my post would be Deputy Manager for this care-home with a salary of over £22,000, but I will get paid about £18,000 a year. It is easier to get a work permit as a deputy manager than as an ordinary staff nurse.<sup>112</sup>

This perhaps is a win-win situation for both parties in the arrangement: vulnerable employees find jobs and get extra hours of work and employers get a cheap workforce. However it is also a clear example of manipulation of UK immigration and employment regulations.

A common phenomenon is that Nepali migrant nurses must work as many hours as possible, irrespective of their initial visa status. Many who came to the UK to do NVQ courses have to pay their fees for these courses and their visa extensions, etc.

Nurses' long working hours are clearly illustrated by Usha, whom I interviewed in Hastings in the summer of 2008. I had arranged an interview with Usha in early April, and I had difficulty finding a mutually suitable time for the interview. I was in Hastings for four days, and all that time she was working. She told me that she tried to work many hours a week in a series of nursing-homes in the area, and she was very tired. She had left her husband and two children in Nepal and was desperately trying to save up and bring her family over in the UK as soon as she could. The day before I was to leave Hastings, I managed to get some time with her, but only after eight pm in the evening. She was living in a shared house with four other Nepalis, three of whom were also nurses. I arrived a little early and met another nurse. We were having a conversation about working and living in England when Usha arrived. She told me that she had to go to London the next morning, and she told me she was very tired and busy, but was happy to talk to me. Her story goes like this: she had completed a night

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<sup>111</sup> Conversation with Sheila, on 12<sup>th</sup> of March 2009, in Edinburgh.

<sup>112</sup> Interviewed on 17<sup>th</sup> of May 2007, rural Northumberland.

shift the night before, returned to her flat in the morning; had a couple of hours' sleep; then she was booked for an evening shift in a different nursing-home. She did that shift too. The day I met her was her only free day in that week, but she had to go to London to sort out her student visa status as her visa was about to expire. First she would have to go to a college in East London and enrol on an Information Technology (IT) course. She could do that relatively easily, as she knew an agent there who helped her obtain all the necessary documents. She had to pay a fee for this service as well as the course fee, and she was then ready to apply for a student visa extension. When she returned to her flat in the evening, she said that she was absolutely exhausted, and had a long day shift booked for the next day. She worked as many hours as she could get, as there was no guarantee of work for the day-after-next and for the next week. She mentioned that she had not seen her six and nine-year-old sons for two years. She would speak to them on the phone regularly and she would instruct her husband from a distance on how to look after the children. She said that she missed them very much, but she was doing all this for her family and for the children's future, hoping that soon they would be reunited. Many nurses worked like Usha to save up enough money in their bank account, to satisfy a visa officer to grant their family a dependant visa.

Another nurse in Hastings revealed:

We came here to work, so I have to work. Some weeks I work 60, 70 and I have worked up to 80 hours in a week. I have to do this to support my family and to survive here. I am hoping to invite my sons here soon.<sup>113</sup>

The above discussions clearly illustrate that after experiencing work-related culture shock Nepali nurses end up working as many hours as possible to become economically viable in Britain. This is not just the situation for Nepali nurses, however, but a common experience for many overseas nurses in Britain (Buchan *et al.* 2005; Smith *et al* 2006). Having indicated the initial shock the nurses experienced at their workplace, I next consider what kind of working relationships nurses have with their colleagues; managers, patients and residents, patients' relatives.

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<sup>113</sup> Interview on 4<sup>th</sup> of April 2008, Hastings, England.

## **B. Working relationships with people at work**

New staff members in any working environment need to be socially integrated and fully accepted by their colleagues in order to establish good working relationships. For many overseas nurses, however, racial discrimination and harassment at work acts like a barrier to good working relationships. In many instances, new overseas nurses are not fully accepted and welcomed by an existing workforce and some feel excluded. Sumi described, in detail, her poor working relationship with her colleagues and manager. Racism and discrimination at work has been one of the most widely-reported and discussed experiences of migrant nurses globally, as well as being the subject of extensive research. Kingma (2006) presents some examples of British nurses experiencing racism, harassment and discrimination in Australia; and Jamaican nurses encountering similar experiences in the USA. There has been considerable research and discussion on overseas trained, and also black and ethnic minority nurses, being victims of discrimination in the UK healthcare system (Dalphinis 2007; Larsen 2007; Smith et al. 2006; Winklemann-Gleed 2006; RCN 2005).

Racism and discrimination are experienced in different forms and expressed in various ways. Sumi's story with which this chapter started is just another example of overseas nurses being targeted. Some nurses also feel that patients, as well as their relatives, prefer to be looked after by white nurses and this is, of course, a form of racial discrimination. I would like to present a few examples of nurses' experiences of racism and discrimination at work, starting with their relationship with the patients they look after and these patients' relatives, and moving on to discuss their relationships with colleagues and managers.

### *Relationship with patients and their relatives*

Maya, who told me that she did not even understand the meaning of "residential home" before coming to Britain, explained that it can be very humiliating when residents and their relatives do not accept overseas staff or regard them as qualified and skilled nurses. She had regularly experienced some measures of rejection from people she has looked after, and had witnessed her work colleagues suffering in similar situations. She illustrated her case with an example:

...a retired elderly man who worked in the Air Force during the war, he used to shout out loud and said “where am I, where am I”. I told him that he was in England, in a nursing-home near his family home. He said “It does not feel like that, there are so many black people here”...this nursing-home is staffed heavily by foreigners, we have Indian, Sri Lankan, Polish and other European [including herself, a Nepali] staff in this nursing home.<sup>114</sup>

She made the further point that establishing a trusting and good working relationship with work colleagues and patients’ relatives is also very challenging. Other nurses also expressed how hard it was to earn trust and recognition from the patients’ relatives. One expressed her frustration this way:

...this probably does not happen to you [indicating me as a nurse]. It is very hard to establish a good working relationship with relatives and families. I’ll give you an example. I was working in a nursing-home one afternoon. I have a full nursing registration, I was the only qualified nurse on the ward, and I was in charge for the shift. In the afternoon, relatives and families came to see patients, some of them went to talk to a carer, a white staff member to find out about a patient and how she had been over the last few days etc. They would not come to me but they by-passed me and went straight to a carer. I felt it was not the qualification or experience they [relatives] were interested in but the skin colour of the staff.<sup>115</sup>

Although these examples indicate that overseas nurses can be subtly rejected by nursing-home residents and their relatives, not many nurses openly and voluntarily mentioned that they found difficulty establishing and maintaining relationships with patients, possibly because their working relationships with patients and relatives may seem like a secondary issue, compared to the many other major challenges nurses have to face at work. Perhaps because of the patients’ dependency, elderly and vulnerable people are not usually in a position to question nurses’ actions, or perhaps it does not happen so often. But when a patient does comment, they can sound fairly severe, as Maya felt above. A stressful working relationship with colleagues and managers however was mentioned by many, and more frequently.

#### *Relationship with colleagues and managers*

Sumi said her manager always tried to be politically correct and started conversations by saying “*a very good friend of mine is Indian*”, then moving into “*this is how we do things here*”, and then becoming personally critical. She felt that people at work have various types of racist behaviours, and not all are totally transparent and easy to

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<sup>114</sup> Interviewed on 17<sup>th</sup> of May 2007, rural Northumberland.

<sup>115</sup> Interviewed on 9<sup>th</sup> of May 2007, Dundee, Scotland.



explain. Her manager harassed her in a very subtle and “politically correct” manner. By trying to present herself as not racist but rather a friendly person, with an Indian friend, she was trying to give the impression of being non-discriminatory, but the way the manager picked on Sumi was racial harassment. Some other nurses felt that they were “watched over” or “policed” by their local colleagues and these experiences are not uncommon and are described by many (Allan & Larsen 2003; Winkelmann-Gleed 2006). This type of working relationship excludes overseas nurses from work-related socialising. Many told me that because they felt so excluded they started isolating themselves from social engagements.

Nurses regularly felt discriminated against. As already noted, when local staff members make mistakes they are dealt with differently compared with similar mistakes made by overseas nurses. Hema, then working in East Sussex, had met some British people in Nepal before coming to the UK. She had an image of British people as very friendly. But when she started working in London, she felt that not all are as she had imagined them. She further reported having witnessed local nurses hiding and covering up each others’ weaknesses and mistakes, but overseas nurses were treated differently. Hema illuminates this further:<sup>116</sup>

Hema: ...I had met some British people in Nepal and I thought that they all would be very polite, friendly, all very nice, very kind, and caring. But I found only 2-3% people like that. The rest are jealous, back-biting, dirty talking, swearing, racist, like that... I have this frustration. There are a few very nice people, too, but the majority of them are racist, some can be nice to your face but stab you in the back. If a local [white] makes any complaint against a foreign staff member, the manager would listen, the managers would listen to local white, but if a foreigner makes any similar complaint they all get together and isolate the person who complained, and gang-up against the foreign staff. So there is very little point to make any complaint.

Radha: ...they would listen to complaints made by locals, but not by the foreigners? Can you explain it a bit more, please?

Hema: ...for example, the place where I work now, there are European and overseas staff. If a local makes a complaint against a foreigner the manager would listen and take action against the foreigner [nurse]. But, if a foreigner does the same, the manager would gang-up with the staff [local] and isolate the person who makes the complaint. Because of this, many overseas and mainly Asian nurses do not go to the manager with any issue. This is totally frustrating. I have seen this happening to my friends, so it feels like it can happen to me as well. Sometimes it is so frustrating; they cover up the mistakes made by the English staff...

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<sup>116</sup> Interviewed on 2<sup>nd</sup> of April 2008, Hastings, England.

She said if local nurses make a mistake, it gets covered up swiftly. She, and a few of her colleagues, discovered that there were some drug errors and drug misuse in her nursing-home, and they thought that they knew the person who was doing it. The Manager took no action and it was covered up very quickly. (Hema went on to explain to me but she asked me to turn my recorder off, as she did not feel comfortable to record it all). Smith *et al.*'s study (2006) also shows that some healthcare managers react differently to mistakes made by overseas nurses compared to those made by home-trained nurses.

### *Occupational socialising: language and culture as barriers*

On the whole, having a common language and a shared culture makes socialising at work easier. Migrant nurses are socially disadvantaged in coming from different socio-cultural backgrounds and having a lack of proficiency in English (Winkleman-Gleed 2006; Smith *et al.* 2006). Although most of the Nepali nurses I interviewed spoke very good English, they have found many of their British counterparts very unwelcoming and exclusive. Some felt that their main weakness was English language. Kiran in Hastings said:

...our communication skill is poor. However hard we try, people here do not understand our accent. We have communication problem, this is the main problem. For example, from when I was young, I spoke with British and had English medium education [went to an English-medium private school in Nepal]. I worked in Nepal with British people too. It is quite different to communicate here with a mass from communicating there with an individual. This is our main weakness, communicating here... some staff members try hard to understand us but the residents and the visitors, they don't understand us; I feel this is our main weakness.<sup>117</sup>

This is perhaps a barrier to socialising at work, but it is a barrier created as well as fuelled by the current institutional regulations in the UK, with discriminatory practice imposed by the UK nursing regulatory body, the NMC. I totally agree with the NMC policy that all nurses should be able to communicate clearly and effectively with their clients and colleagues at work. The NMC, however, has double sets of rules for overseas nurses, depending on the nurses' nationality, EU or outside the EU. As we learned earlier, from August 2006 (and still as of August 2010) the NMC registration process demands that nurses who are from outside EU countries must achieve an IELTS score of 7 in each aspect of English: reading, writing, speaking and listening.

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<sup>117</sup> Interviewed on 10<sup>th</sup> of February 2008, Hastings England.

But this is not necessary for nurses coming from Spain or France, or Poland and other EU countries. The registration policy requirement in itself is discriminatory in nature. If nurses are to offer a good standard of nursing care to people, either all nurses from non-English speaking backgrounds need IELTS score 7 or they do not. There should be one professional standard which does not depend on nurses' nationality. This type of institutional discrimination and regulation based on nationality only adds further to Nepali nurses' feelings of vulnerability, and makes them feel that they are weaker than EU nurses and that their practical nursing skills and caring attitudes are not taken into any account at work. Overseas nurses' competency is assessed by the NMC against their nationality and English ability, not their clinical skill and caring and compassionate qualities.

Cultural differences can also play an important role in nurses' socialising. Amongst the Nepali nurses I met and interviewed, some follow Hinduism and some Christianity, and some do not practise religion at all. One Hindu nurse commented that she still does not eat beef, as the cow is a holy animal for Hindus. She did not want to share a flat or kitchen with her work colleagues as they would eat beef and she did not feel comfortable even going out with them for the evening. Since I considered religious belief to be a private matter, I did not actively explore the nurses' beliefs, although if they had an issue or wanted to express something they could do so. Religion and culture appeared to be important issue that affected some nurses' social lives.

### *Dealing with racial issues at work*

After recognising that racism, discrimination, and harassment at work exist widely, in 2005 the Royal College of Nursing (RCN) UK developed "RCN good practice guidance for employers in recruiting and retaining" overseas nurses, within the Working Well Initiative (RCN 2005). This good practice guide suggests that employers offer some degree of orientation and training for local nurses about overseas nurses' situations, so that overseas nurses can integrate better socially and a good work and team environment can be built. This is certainly a good idea, but it appears to have very little effect in everyday practice. I have not come across any of these kinds of programme, either within the NHS or in the private sector. The British NHS is an equal opportunity employer in theory, but many migrant staff still

experience racism from their colleagues, managers, and patients and relatives in practice.

The RCN and UNISON are the main trade union bodies for nurses in the UK. Mainly from 2002, after the British media started writing about overseas nurses being exploited in Britain (BBC News 2005; Red Pepper 2004; BBC News 2002) both organisations have been actively involved in advocacy and lobbying work to improve the working environment for overseas as well as black and minority ethnic (BME) nurses.<sup>118</sup> RCN and UNISON have regional branches in various part of Britain, with a network group for overseas nurses in order to facilitate a better support network for them.<sup>119</sup> Not all overseas nurses are members however. I interviewed a nurse in Hastings who was opposed to joining either of these bodies, firstly because the membership fee was too expensive (about £15 per month for a full membership) and secondly because she did not have much faith in them. She echoed Sumi's experience, in her description of the discriminatory practices in the British healthcare system as being so subtle that even the RCN cannot do much to tackle them. In short, nurses' trade union organisations are not fully effective in dealing with subtle issues.

#### *Migrant nurses and career progression opportunities*

I feel that it is too soon to examine Nepali nurses' career progression and the opportunities that are available for them. As already suggested in the discussion above, during the fieldwork, many nurses were trying to find a permanent nursing job and a work permit. Some had just found a permanent position, and some were trying to find training placements. They were looking for some job security first. They were not that well-paid either. None of the nurses' past qualifications and experience had been recognised or were valued in the UK, so all had started from the bottom of the UK professional ladder. Career progression was not a major issue for the majority, as they are preoccupied with the above issues. There is, however, plenty of research literature available which suggest that migrant nurses do not get the jobs they are qualified and experienced to do. In terms of promotion opportunities even in the NHS,

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<sup>118</sup> Information on their activities can be found in their websites, [www.rcn.org.uk](http://www.rcn.org.uk) and [www.Unison.org.uk](http://www.Unison.org.uk).

<sup>119</sup> There was an overseas nurses' network group in Edinburgh, set up in 2005. It remained active for a couple of years but recently has been very quiet. As an overseas nurse and a researcher I am still a member, though the group has had no activities for a while.

where working terms and conditions are considerably better than in private sector nursing-homes, many overseas nurses experience career stagnation. For any promotion, overseas nurses have to be exceptionally good to get into their desired positions (Smith *et al.* 2006; Winkleman-Gleed 2006; Allan & Larsen 2003; RCN 2007). Career promotion opportunities in private nursing-homes are far less or almost nil for overseas-trained, and nurses from ethnic minority backgrounds.

## **Conclusion:**

This chapter has highlighted that many Nepali nurses come to the UK with very unrealistic work expectations. They bring with them work experience in very different types of nursing posts, from the one in which they find themselves employed in the UK. This chapter further illustrated that Nepali nurses' expertise and qualifications are not valued, and consequently their experience and skills are wrongly placed in a British healthcare system. For the majority of nurses from Nepal, migration to the UK means a downward professional move, as it is for other overseas nurses (Larsen 2007). After leaving a successful professional career behind, they come to the UK to take up the very least desired type of work and in sub-optimal working environments. Many have experienced work-related culture shock. Nurses' salaries and benefits are not very attractive and some are not even paid unsocial working hours enhancements. Despite difficult working relationships with colleagues, and regularly feeling rejected by their clients and relatives, many nurses are forced, by their circumstances, to work extra shifts whenever any opportunity is available. Compared to the working terms and conditions in private nursing-homes, NHS work is perceived as relatively better by most Nepali nurses. They would like to move to the NHS sector but have no choice but to wait for 'Permanent Residency', which takes five years working full-time with a work permit.



Figure 7.1: Chanda, with baby Manjesh, during his *Pasni*. Edinburgh, April 2010.



Figure 7.2: NNA-UK AGM in London, 24<sup>th</sup> August, 2010. (Photo by NNA-UK, reproduced with permission)

## **CHAPTER SEVEN**

### **FAMILY AND SOCIAL LIVES IN THE UK: EXPECTATIONS AND REALITY**

The previous chapter has illustrated how the nurses I met were disappointed with their working conditions, as their high hopes were not fulfilled in the UK. I begin this chapter by examining their living situations: how have nurses and their families re-adjusted and adapted in the new environment. If they have found the life they had aspired for, what are their social support networks in the UK? I go on to discuss the overall migration experience of nurses and the new hopes and strategies they develop for a better future.

#### **A. Living situations and social lives**

The nurses I interviewed in the UK were living and working in diverse locations, from big cities like London to rural areas in Britain. In bigger cities they have larger social networks. Many live near their friends, and some even share houses or flats with another Nepali family. Some of the nurses and their families seem to have a small but close social support network. With the significant increase in the Nepali migrant population since 2001, from around 5000 in 2001 to almost 50,000 in 2008 (Sims 2008), several new Nepali Diaspora networks have emerged. This will be explored later. Most Nepalis live in and around London and the South East of England, and the networks there organise cultural events and functions to celebrate Nepali New Year and other major festivals.

If we look at just nurses and their families, in April 2008, there were several hundred, many with their families, in London; thirty five nurses and their families in Hastings; several nurses and their families in Reading and in Oxfordshire; ten to twelve nurses in Aberdeen; five in and around Dundee. All live in small clusters. These are only a small sample of places, as I could not visit all the locations in which, I have been reliably informed, Nepalis live. In cities and towns such as Southampton, Eastbourne, Liverpool, Manchester are centres, with others in East Anglia, north Wales and many rural locations.

When I visited Hastings in February and April 2008, I met nurses and their families who were living in clusters of two to three families in a house with two to three clusters in one street. I was informed of similar clusters in East London in the Carlton area and in West London, in Wembley, Southall, and in Harrow on-the-Hill. Some nurses in Hastings were living in the town but working in rural nursing-homes, ten to twelve miles outside Hastings, but within commuting distance. Hema said that she chose to live in Hastings for the social network and support, and for her children to meet other Nepali families, while she was working several miles outside Hastings in a rural nursing-home with a regular train service.

Many other nurses are rurally based too, across Britain. Those who are in rural areas seem to be quite ‘cut off’ socially from other Nepalis and they did express feelings of isolation. When I visited some of the rural nursing-homes, there was very limited public transport: very infrequent services especially in the evening and at weekends. These nurses did not have their own transport and they seemed totally isolated and almost trapped in rural villages. Those Nepalis living in rural areas are often the only Nepali nurse or family in the village, so not much happens outside their work and school. Children lack friends with whom to play, and husbands cannot find proper jobs, so they too feel isolated and lonely.

I went to see Sara who was living in nursing-home accommodation in rural Buckinghamshire, several miles outside Bicester, near Oxford. We arranged to meet after her morning shift that was due to finish at 4 pm. I planned to be there for around 4.30 in the afternoon, but found there was no transport. I had to take a taxi from Bicester. I discovered that there was no public transport of any kind after 5 pm. When I was ready to return I had difficulty finding even a taxi. The nurse said that because of this lack of transport she could not go out very often to Oxford itself or any nearby towns. She went food shopping once a week but she had no flexibility, as to miss the last bus would have put her into great difficulty.

Another nurse, Indra, with whom I spoke on the telephone in March 2009, said she has been living and working in a rural nursing-home in Lancashire since coming to England in 2004. Her husband and children joined her in 2006. She told me that her family are the only Nepali people in this village in the heart of English countryside. The village is very small and almost an hour’s bus journey from Preston. They hardly



saw any other Nepalis for months. She did not have many friends there either and so she spent time either working or with her family. With nothing much happening in the village for her children, they spent many hours on the computer every day.<sup>120</sup>

Wherever they are, in general migrants usually live in poor and cramped housing conditions. Some accommodation is provided as part of a work contract, but this is usually more expensive than the ordinary going-rate (Castle 2000; Shelleys 2007). If a nurse is new in the country and with no other social support, she has little choice but to accept and try being thankful for whatever is available. Nepali nurses' situations are no exception. I have seen many nurses' living conditions and accommodation and it seemed similar to that described by Castle (2000) and Shelley (2007): rundown, rough, cramped and overpriced. I met nurses who had recently arrived in Britain and their accommodation was arranged by the employers with fairly expensive rents. I met nurses in Hastings, Oxfordshire and Scotland who were sharing a house with other migrant nurses and the property was owned by their nursing-home employer. In urban hubs and in isolated rural areas, wherever they were, most nurses' accommodation I visited did seem quite rundown, and some nurses were living in worryingly rough parts of towns.

When I was in Hastings, I was making the five minute walk, going from one house towards another nurse's house. It was late morning, near the local train station when I encountered a group of rough-looking youngsters. Some seemed drunk. I felt unsafe, as there were no other pedestrians around. I ran quickly, but know that if I lived there, I would not be able to walk around there in the evenings or at night. Nurses who lived there said they ask their husbands and friends to escort them to and from work.

In a tranquil rural village, or in an urban hub such as Hastings, in a "mini Nepali village", wherever nurses lived, many have found their social lives restricted and very different from their dreams and hopes of life in the UK. Their social lives are restricted for a number of reasons. Firstly, as we have seen in the previous chapter, many nurses work so many hours a week that they have no free time. Secondly, many do not have families in Britain. They miss their families and loved ones, and many also find it very challenging to make new friends in a new place.

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<sup>120</sup> Telephone conversation in March 2009.

Gradually, however, some nurses start to look for better social networks (as well as better jobs). When these opportunities arise, nurses move to be near their friends and families. For example, Sumi (whom I introduced in the previous chapter) moved to a Scottish town to be near her relative. In March 2008, two other nurses and their families have moved to rural Scotland, to a village near St. Andrews: one found a job and moved there first, and then suggested that her friend move there too. Within a few months, her friend secured a post in the same nursing-home and moved there to be near her friend; a form of chain migration.

*Social life: also a delusion*

Kiran (whom I introduced in Chapter Four) not only had the wrong work expectations, but she also told me that she had completely the wrong ideas and images about Nepali nurses and their social lives in Britain. She giggled as she told me this, appearing slightly embarrassed to share her personal feelings openly. She used to receive holiday photos from her close friend who migrated to London with her husband in the mid 1990s. Her friend's husband was a British Gurkha. She explained to me about the photos and what they had meant to her:

...here she used to send us photos, always looking very pleasant and happy. She only sent happy-looking photos... [She giggles]. She used to stay in Lewisham in London. Quite a lot of Nepalis live there. She sent us photos of *teej*, *dasai*, and *tihar* [major Nepali Hindu festivals]. And she lived near her family and relations, so photos with her *didi-bahini* and *daju-bhai*, like that. All looking happy, always on holiday, like they never knew about any difficulty. So I had prepared myself and aspired for that kind of life. Their photos of wearing saris and so much golden jewellery like that, it all looked very nice...

Kiran further explained to me that seeing the photos she wished to be there too, but it felt almost like a dream to her then.

I thought if we get to go to the UK, we will all have a fantastic life, happy in a society with high living standards and a technologically advanced system.

Although her friend was also working as a carer in a nursing-home, one thing her friend never mentioned or shared with others was her working situation and her social life outside her close network. Kiran could not really understand what it would be like to work and live in the UK, and her friend's photos did not really give her a full

picture of work or social life. Once here in the UK, Kiran found social life quite different from what she had imagined:

We don't get time to see even our close friends much, so I have no social life or a very restricted one.<sup>121</sup>

Kiran lived in Hastings, with many Nepali nurses and their families nearby. In this way, she is better located than many others. She even shared a house with another Nepali couple. Yet she still found her social life restricted. Many nurses who live in rural Britain also find their social life very restricted.

I met Maya and her family in rural Northumberland. They were the only Nepali family there and did not find their social lives stimulating in that setting. She said that she had almost no contact with other Nepalis when she first arrived there.

After arriving in London on her own in 2004, Maya was sent to this place where she completed her adaptation. When I met her in May 2007, she had been living in that village for almost three years; the first two years on her own and the third year with her family. She shared her initial experience of living in the village on her own, leaving her family back in Nepal with no Nepali friend nearby. She said:

...I used to work usually six to seven days a week initially, sometimes long days...and after the shift I had no social life. I would work in a nursing-home, come home after the shift, then nothing, no family here and no friends nearby. I was desperately missing my family. I lived on my own for two full years, and I lost so much weight, I was getting much thinner. I used to write and post letters, and I used to go to the village post office. There is nothing in the village, one church, one pub, a local shop and a post office. The post office was closed down a few years ago; after this I felt that there was nothing in the village left for me. Food and other items are very expensive here. I went to Newcastle a few times to meet up with other Nepalis. There was nobody to talk to or do anything with or any activity at all in the village. I felt so lonely and with no social life I started going to the village church. My family joined me a year ago, it is better for me now...<sup>122</sup>

As this quote shows, Maya missed her family terribly, felt lonely and isolated but she had to live there. She did not bother to cook regularly for herself and so lost much weight. Even after she went to the local church, to see if she could meet and talk to people, she did not have much success. She found making friends and socialising in a village very challenging.

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<sup>121</sup> Interviewed on 10<sup>th</sup> of February 2008, Hastings, England.

<sup>122</sup> Interviewed on 17<sup>th</sup> of May 2007, rural Northumberland, England

### *Reshaping a new social life: a challenge*

All migrants have to restart their lives in a strange society. Creating a new social network is not always easy, and it has not been easy for Nepali nurses. Some socio-cultural differences make it harder for newcomers to integrate with locals in an alien place: new food customs and new religious practices are encountered, and need to be adapted to in order to becoming gradually assimilated into a new (and increasingly multicultural) society. Differences might seem relatively small, but they affect nurses in their everyday life and in social integration processes.

There are some other more prominent barriers to socialising with work colleagues and local people. Sumi had lived on her own and, as we found in Chapter Six, it was difficult for her to mix with locals and work colleagues in Dundee. She sadly expressed:

Yes, social life. I thought that it would be different. In a foreign country, I had higher expectations of living standards and social life. Sometimes it seems like I am in Nepal, as the living standard is not different, now I am sure that I was day-dreaming on that day and thinking that I was in Nepal. It does not seem strange or a high standard where I live now. Just a few days ago, I was at work, a person with blonde hair walked in, I thought this person is in Nepal, has come to visit Nepal. For a second I thought that this person was a tourist in Nepal. I must have got completely lost [she giggles]. When I first arrived I went to Eastbourne, there I spent so much time with other Asians, and it did not feel like Britain at all, I did not get any chance to learn about social life in Britain. Then I moved here [Scotland]. Here too I don't socialise with the locals or work colleagues, I don't interact with them. I am not like that, sometimes they invite me for a night out, and I don't go... If you don't go once or twice, they would not invite you again. I am not that kind of person... I got invited out a few times but I did not go so they don't invite me again... I go out with work colleagues only for work related stuff that is all. I have no personal relationships.

Radha: So, you don't mix with the local work colleagues much. What do you do on your day off, or in your holidays, how do you spend your time? You said that you sleep a lot, apart from that?

Sumi: ... I sleep a lot, sleep until about 10-11 in the morning, when I am not working. I invite my *dai*, *didi* and friends, whoever is there and is free to come on line [in Nepal] when I am free here to chat online. I watch television. I go to the library and borrow a film, and watch it. Sometimes I go and see my Nepali friends and other times I watch DVDs or just sleep.<sup>123</sup>

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<sup>123</sup> Interviewed on 21<sup>st</sup> of June 2007, Scotland.

As the interview progressed, Sumi further revealed that she did not want to socialise with her colleagues; she would rather spend time chatting with her friends and families in Nepal.

Socialising with locals has proven a difficult task for Sumi in Dundee and Maya in rural Northumberland. Similarly, many others felt lonely, missing families and friends back home. Understandably until their family joins them in Britain, nurses try to stay in touch as much as possible.

#### *Social cost of migration: family separation*

Like Maya, Sumi and Kiran, almost all nurses have to make their first journey to the UK on their own, leaving their families and kin behind. This is because of work-permit and family visa regulation, not by choice. There is a time lag before nurses' families can join them in the UK. The most common pattern appears to be: nurses migrate on their own first, then they find somewhere to live, obtain their nursing registration with NMC (as discussed in Chapter Four), find a full-time nursing job, build up some money in the bank, and sort out their work permit. Once they get to this stage, they can invite their families to join them. They have to show UK Home Office border control agency that they can financially support their dependant family members. Reaching this point seems to take them on average between two to three years.

Fifteen out of twenty-one nurses I interviewed had migrated to the UK leaving their young children and husbands behind; three others were single and the remaining three nurses came to be reunited with their husbands. During the fieldwork I met nurses at various stages, from some newly arrived in the UK to those settled with their families here. Some nurses were in the process of inviting their husbands and children to join them. Those who have husbands and children in Nepal seemed to have missed their families greatly, but had remained in touch with them regularly. Sabita migrated to the UK leaving her husband behind; she had been married for only a year when she came to the UK. When I met her first, she said:

I used to phone him and still do every day, I used so much money on the phone... it is hard to live like this, but we have no choice, I have to have a work permit visa first then I can invite him over, we are in the process now.<sup>124</sup>

Usha had left her two children and husband behind and when I met her, she was still looking for a full-time job. She explained:

...I speak to them regularly. I miss them so much, I tell my husband to look after them... *mitho-mitho khane kura dinus bhanchhu* (I tell him to give children tasty-tasty food or the food they like to eat). Hopefully it won't be long before they could come here.<sup>125</sup>

Like Usha, all the nurses lived in a transnational world, and those who had left their children behind were providing "long distance mothering" care (Zimmerman *et al.* 2006; Lan 2006; Parrenas 2005). Nurses constantly live between two worlds, physically in Britain and emotionally trying to re-connect with their loved ones in Nepal. These are some of the social costs migrant nurses have to pay.

On many occasions during the fieldwork for this research, I felt all too close to home. Being a mother, when they started to share their pain of family separation, and about how much they miss their children, it was almost too painful for me to listen to their stories. I interviewed Sabita in Scotland in the summer of 2007, when she was in the process of inviting her husband to join her. Next, I had a telephone conversation in 2008, after her husband had joined her and they were expecting their first baby in early 2009. In August 2009, I met a friend of hers and enquired about the mother and the baby, and learned that Sabita had taken her baby to Nepal and left him there to be looked after by her parents, whilst she and her husband returned to the UK. The reason for this, I was told, was because of child care difficulties in Britain in the absence of extended family support networks.

Modern technology has been very useful in helping nurses to stay connected with their families and friends in Nepal. When I was with them, I saw many nurses talking to their families, husbands, children and other relatives in Nepal. Sumi kept in touch with her friends in Nepal and internationally, she said:

... My close friend is here. Now, here [in the UK]... the person who just phoned me a few minutes ago, [she had received several phone calls during this interview] she is one

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<sup>124</sup> Interviewed on 21<sup>st</sup> of June 2007, Scotland.

<sup>125</sup> Interviewed on 1<sup>st</sup> of April 2008, Hastings, England.

of my best friends, from the hostel, my roommate [from nurse training time], some are here, one is in America, we do have regular chats, I don't miss them. But the people I miss are my parents and my *dai* and *didi* [elder brothers and sisters].<sup>126</sup>

Many are able to use the internet to chat and some use cheap mobile calls. Eventually, some of those dependant families left behind are reunited.

When Maya became more established, she invited her husband and two children to join her: the children started school and a few months later her husband found a part-time job in a co-operative supermarket nearby. After they arrived, Maya said she started eating regular meals with her family; she regained her health and put on some weight. She was happy, but her family did not like living in a village. A year later, her children felt that they had had enough of living in a rural area and wanted to move somewhere where there were other Nepalis. She started looking for another job in 2007. She contacted the same agent who had initially helped her find her first job. This time the agent offered her a few choices of nursing-homes. One was in rural Oxfordshire, which she felt was even more rural than where she was. The next was in Callander, a small town in Scotland with almost no public transport. Her children did not want to move there as they too thought it would be worse than where they were already. Finally, she found a nursing-home job in London, and moved there a few months after I met her for this interview. So, within a year of their arrival, she had to find another job, and they all were uprooted to London. Some other married nurses have been through the similar pain of family separation, shared the joy of being reunited, and then had to adjust together to different issues that relocation involves.

*Family re-united: another dream comes true, but are dependant husbands happy here?*

In addition to meeting with the nurses, I also met some nurses' husbands and children in the UK. After spending some time with their families, I learned that not all husbands were happy with their move, and that some have found it very hard to adjust in their new environment.

I met thirteen nurses' husbands: eight were husbands of the nurses I interviewed, and five men I met less formally and conversed with them. I have been in touch with some

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<sup>126</sup> Interviewed on the 21<sup>st</sup> of June 2007, Scotland.

of their families regularly and I have noticed some major challenges with social adjustments for these men that result from changes in gender roles and traditional Nepali family dynamics. Generally, Nepali men are perceived as being the heads of their houses and the main bread-winners. They take the main decision-making roles and the majority of men enjoy higher social positions than women in Nepal. Their arrival in the UK, when they become migrant nurses' dependant husbands, challenges their family role and social position. Their wives have better job opportunities, often speak better English and have better earning potential in the UK. Moving to Britain as a dependant husband means men have to make compromises in their social positions, sometimes giving up their respectable jobs in Nepal only to find themselves moving into undesired, low-paid, 'supermarket-shelf-filling' kinds of jobs in the UK. The table below illustrates what nurses' husbands did in Nepal before their migration and what they were doing at the time of meeting with them.

**Table 7.1: Nurses' husbands and their social / professional position after migration**

| <b>Id number</b> | <b>Last job in Nepal</b>                              | <b>Job in the UK at the time of meeting</b> |
|------------------|---|---|
| 01               | Senior government officer                             | Tesco shelf-filler                          |
| 02               | Academic administrator                                | Security guard                              |
| 03               | Laboratory technician (permanent government position) | Supermarket shelf-filler                    |
| 04               | Private businessman                                   | Carer in a nursing-home                     |
| 05               | Private businessman                                   | Security guard                              |
| 06               | High ranking social scientist / consultant            | Carer in a nursing-home                     |
| 07               | An INGO worker  | Carer in a hospital                         |
| 08               | Computer technician                                   | Carer in a Nursing home                     |
| 09               | An INGO officer                                       | Support staff in NHS hospital               |

In addition to the above nine men, I have encountered several other nurses' husbands in Hastings and other places, albeit very briefly.<sup>127</sup> Their wives informed me that, after arriving in the UK, some of these men started working in restaurants in Hastings.

<sup>127</sup> I do not know their professional backgrounds and they are not included in the table above.



After a period of joblessness and frustration, some of the men got together and decided to start their own Nepali restaurant business.<sup>128</sup> Some of the men found the work in supermarkets as shelf-fillers, and in nursing-homes as carers, quite demoralising. It was even harder to tell their friends in Nepal what kind of jobs they had found in the UK. Some of the nurses' husbands (whom I met and got to know a little better) shared their frustrations informally. I present two nurses' husbands' stories to illustrate how Nepali men experience their lives in Britain as dependant husbands, with compromised social positions.

I met Prakash (05 in the table above) in Spring 2007. He told me before moving to the UK he was running a small but successful business in Kathmandu. When his wife expressed her desire to migrate, he agreed with her and fully supported her wishes. They sold his business and used the money to pay the migration broker in Kathmandu. After a period of negotiation with this broker, they agreed to pay the top amount, which would guarantee her a work permit for four years. They wanted to have this guarantee after selling their business, so that she would not face any problems with finding a job. All went well and she migrated to the UK first, found a job and completed her adaptation training in a nursing-home in Eastbourne. She found a full-time job, worked hard, saved enough money and invited her husband and six year old daughter to join her. Prakash told me, however, that after his arrival here he had great difficulty in finding a suitable job. After all possibilities were exhausted, they moved north hoping that it might be easier for him to settle there. After spending the day with his wife and his six-year old daughter, Prakash insisted that he would walk with me to the train station. As we walked, he revealed that he felt bored as he had no job: he had nothing to do and no social life. He said:

I started drinking, I was just too bored and felt isolated, I did not realise how much I had been drinking every day, and it made me feel bad.

When his wife is at work, Prakash does all the housework, which would be routine work for women but not for men in Nepal. While I interviewed his wife, Prakash cooked lunch for all of us.<sup>129</sup>

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<sup>128</sup> When I visited Hastings in 2008, there were three Nepali restaurants, all opened in 2007-08.

<sup>129</sup> It is unusual for a Nepali man to cook lunch while his wife is sitting and chatting with others.

The next case study is of Deepak (06 in the table above). He is a well respected professional man, with an MSc in Sociology from Tribhuvan University in Nepal. After he completed his degree, he joined an INGO in Nepal. He worked for many years in the rural development sector, had been involved in Action Research, worked in Afghanistan for the Japan International Cooperation Agency (JICA) as an international expert, and had been involved in many key positions, earning well in Nepal. His wife worked in an INGO-run Hospital in the Kathmandu valley. There was so much *hawa* (wind) and *halla* (noise, rumour) about going abroad in 2004-05 and she was “caught by this bug”, Deepak told me. As she was not completely satisfied with the management structure at her work, she wanted to move to the UK and so started the migration process. She paid an agency £5000 and migrated to Britain as an adaptation student. Over a year later, she applied for a permanent position in a private nursing-home. She saved some money and invited her husband to join her. He obtained a dependant visa and arrived in England in January 2008. I met him in Hastings in the spring of 2008, and on many occasions afterwards. He shared his frustration with me:

I get so stressed, there is no intellectual engagement in the village, nobody to talk to, and my wife has to go to work. I feel that I only use 1-2% of my brain, and the skills and knowledge I had acquired in Nepal is useless here. Sometimes I feel that this will drive me mad, I need to get out of it. I cannot live like this for much longer.<sup>130</sup>

Nurses’ husbands who have been living as dependant husbands have had no choice but to accept unskilled jobs. Deepak and some others (as the table above illustrates) had highly respected jobs in Nepal, and for them nurse migration has brought only “downward social mobility” (Charsley 2008; Kingma 2006; George 2000) leading them into frustration and disappointment.

In the summer of 2008, I met several Nepali men in Hastings who had moved to Britain as dependant family members. During an informal conversation one man made a comment and all started to laugh. I did not understand the joke at first, but they kept saying “*yo raniko desh ho*” (“this is the queen’s country”), a country run by the queen (i.e. a woman). Men had to follow women’s rules and their households and families were run by the wives, who were more powerful than the men. They had to explain this to me. Although it appeared a light-hearted joke at the time, it reflects

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<sup>130</sup> Conversation with Deepak, February 2009.

some bitter irony here. Nurses themselves have to face many immense challenges and hurdles in their career before they invite their husbands to join them, but when their men arrive there are then other challenges to face, as their men do not seem to be happy either.

It is not just nurses and their husbands who feel social isolation and the frustration of inappropriate jobs but also young children who have just recently joined their mothers in the UK seem to be facing difficulties too. Binita had left her young son in Kathmandu with her family. She managed to invite him to rural Oxfordshire where he started attending a local primary school. His mother said:

My son is eight now. He does not like it here. He has no friends, no outside life. In Nepal he had lots of friends and used to play outside with local children. This does not happen here. If somebody comes to play with him, they play for about fifteen minutes then they to go back home. My son does not like it here, and he wants to go back to Nepal.<sup>131</sup>

As can be seen nurses, their husbands and children all have to go through many challenges in the new country.

## **B. Overall migration experiences**

When we look back to where nurses' journeys began and see where they are now, it is quite clear that they have negotiated many difficult hurdles and challenges. They have moved on so far, and finally many have been reunited with their families. Despite this, some feel trapped by their circumstances in the UK.

*I am stuck in a "dream trap"*

As I have shown, many nurses' initial migration dreams and desires have proven unrealistic. Like others, Binita migrated to the UK with many expectations and much enthusiasm. After a couple of years, these dreams and enthusiasm disappeared and she felt "trapped" in a nursing-home in rural Oxfordshire:

I used to be very enthusiastic about doing further study and advancing my professional career. Now all my desires and dreams have disappeared. I feel that I am in a trap. I can't move around as my children are here, it is not easy to shop around for jobs, and I can't just go back to Nepal either. When we are ready and our children are settling

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<sup>131</sup> Interviewed on 27<sup>th</sup> of February 2007, in rural Oxfordshire.

better, we plan to go back to Nepal. I want to take them back, but now I feel that I am stuck in a trap.

This feeling of being “trapped” echoes Moti’s experience, as she describes life here as never-ending chain of difficulties and challenges.

Moti felt just like Sumi: so close to getting a job and settling in the UK but the future remained still so uncertain. This is not these two nurses’ experiences alone, as many of them mentioned fear of future uncertainty. I have met and spoken with many nurses who migrated to the UK as students and have gone through very similar experiences. It is not surprising that some have felt it is like getting into a “dream-trap”.

#### *Visa and work permit regulation driving nurses into casual type of nursing*

Nurses have found UK visa regulations are becoming more and more difficult every year, and this has a direct impact on their work opportunities in the UK. Until nurses secure work permits, they feel continuously stressed and increasingly vulnerable. As was discussed, when nurse migration from Nepal started around 2000, it was quite easy for someone to get a work permit and also to switch their student visa to a work permit if necessary. Since July 2006, when the Home Office changed its policy, it has become almost impossible. Now any person with a student visa must return home and reapply for a work permit from there. Many nurses, who came to the UK with NVQ student visas, have to do this, but they have found it difficult to go back to Nepal because they feel that there is no guarantee that they will get work permit visas. As UK immigration policy gets tighter, nurses’ anxieties escalate correspondingly. Nurses would rather continue to renew their student visas by enrolling on education courses and then engage in more casual types of nursing. I have met many nurses in this situation, although not all nurses are willing to share the full details of their visa and work permit situations and their working hours, because it is such a sensitive topic.

According to student visa regulations, they should work twenty hours a week, so no employer would give them a full-time job contract. There is no way they can survive with such a small number of working hours and the resultant small earnings. They are forced by circumstances to take any hours they can. As time progresses, they start to

alter this and increase their working hours, usually ending up doing casual hours. Some have started with very few working hours, and then the hours are increased, depending on how well they impress their managers. Many who hold student visas seemed to be working more than twenty hours a week. One nurse informed me that adaptation nursing students are permitted to work full-time hours, as work is part of their training; but another said that no students are allowed to work more than twenty hours a week. It is not clear to me under what kind of part-time work contracts they work, but many nurses I met were working as many hours as possible, usually more than twenty hours a week and in more than one nursing-home.

Usha migrated to Britain in 2006 as an adaptation student. She completed her training in 2007 and received her NMC PIN. After becoming a fully-registered nurse, she had difficulty in finding a full-time nursing post. In her extreme frustration, she told me that she went all over Britain for job interviews: to Ireland, Wales, Scotland and many parts of England. She felt that her interviews seemed to go well but she just could not get a job. She suspected that it was due to the changes in work permit regulations. These changes make it difficult for a migrant nurse who has a student visa to get a full-time nursing post. Employers are becoming increasingly apprehensive about offering full-time and permanent positions to overseas nurses. Many employers are not prepared to apply for work permits. When they realise that the candidate requires a work permit to work full-time as a nurse, they do not want to proceed. This was exactly what Usha suspected. She became completely exhausted looking for a job and her student visa was about to expire. She had to get a new visa quickly. The easiest way of obtaining one was by enrolling on any course, such as an English language course in a private college, or an IT course, anything. She had employed both routes before. Now, for the third time, she needed to renew her visa, but still had no secure job. She said she did not know which course to join next, and how much to pay an agent for this. In the meantime she worked fifty, sixty and seventy hours a week. The day I interviewed her, she had worked the night before. During the day she visited a private college to enquire about possible courses in order to renew her student visa. I met her again in the evening, and she was working the next day from 8am till 8pm and starting a night shift from 9pm, only an hour after the day shift finished. She said she had to do this in order to pay the fees and send some goods home for her children.

As she had no full-time job and no security, she might not get any work from week to week. She had to take any shifts whenever she could get them, usually casual shifts.

I have found many instances of this type of casual use of healthcare workers in the private health sector in the UK where Nepali nurses work. In whatever circumstances the nurses find themselves, they are not willing to return to Nepal, as they are still keen to achieve their goal of the freedom of mobility.

*No going back without achieving something first*

One issue that the interviews reveal is the apparent loss of *ijjet* - a sense of failure if one returns to Nepal without tangible achievements in the UK. The term used is “*be-ijjet*” (loss of face or social honour). It is *be-ijjet* to return to Nepal without some achievements, after spending so much money, time and emotion. Nurses do not want to return to Nepal without a sense of social pride and the security of having a permanent job with a longer term work permit, or having received permanent residency status. Without this, returning home could be seen as failure. For example, some nurses who entered the UK as students returned to Nepal to change their visa status. Even this visit has been hard and very *lajlagne* (embarrassing) for them. When people ask why they have returned home, they feel they have not achieved anything tangible and that this lack of concrete achievement can be seen by their relatives. It becomes a source of extreme embarrassment.

Kiran, for instance, returned to Nepal in 2007 to change her visa status from NVQ student to work permit holder. She says it took her a long time to sort this out. She was staying with her family in Kathmandu, but people kept asking her the same questions: how long you are here for and when are you going to go back? She found this very hard to answer. She said:

...it's so *lajlagne* (embarrassing or *be-ijjet*) when people asked me what I was doing in Nepal, why I was there for so long. I told my immediate family about my problem with the visa but I could not tell anybody else. After that entire struggle to come to Britain, all that emotion and money investment, we need to achieve something before we go, at least NMC PIN and a permanent job. I could not even tell my grandmother. When I said that I was on my holiday, people said that people in the UK cannot afford to have over two months holiday, so how did I get that time? It was very difficult to tell people what my problem was.<sup>132</sup>

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<sup>132</sup> Interviewed on 10<sup>th</sup> of February 2008, Hastings, England.

Even when migrants really want to return home, they feel they have to wait in order to achieve something in the UK first. Sara was desperate to return home, but could not do so just yet:

When I finish my ONP I will go. I would like to go to Nepal first, like *tufan* [high speed wind; storm, typhoon]! Other things are after that.<sup>133</sup>

As she explained, a return home could only be made after completing her training, so that she could share some positive news with her friends and family in Nepal.

When migrants to the west return to Nepal for a family visit and a holiday, they are received almost with a celebrity-style welcome. Percot (2006) observes while interviewing nurses in India who had returned from the Gulf, that a nurse was treated with a cup of tea by her mother-in-law. A simple observation, but a daughter-in-law in an ordinary South Asian household, with no international migration and earning potential, would not get the same service from her mother-in-law. Rupa, told me of her friend's return to Nepal for a month's holiday from England. She had a massive welcome party arranged by her family and relatives, and after the welcome party, when she went to her room, her bed was covered with rose petals. These types of welcome are signs of the highest social respect. For Nepali nurses and their families, migration to the UK brings significant symbolic capital. Nurses and their families do not have to accumulate a large amount of money, as being in the UK is in itself a big success: it gives migrants' families, friends and relatives much social *ijjet* and enhances their social status.

When nurses feel settled in the UK, after securing jobs and work permits, and once they are joined by their family, they begin to buy houses or flats or other commodities, like cars. They do develop and join new social networks.

### **C. Emergence of support networks:**

#### *Nepalese Nurses Association in UK (NNA-UK)*

In 2007, when I met nurses and their families, some expressed their interest in setting up a Nepali nurses' professional support network. Gradually, the number of interested

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<sup>133</sup> Interviewed on 28<sup>th</sup> of February 2007, rural Buckinghamshire, nr. Oxford.

candidates increased and this group continued to contact Nepali nurses across the UK, using their personal contacts, mainly by word of mouth. The group grew bigger: they contacted nurses in Hastings, and elsewhere in England, Wales and Scotland. After completing some basic work, a group of nurses, led by one of my interviewees in fact, set up the Nepalese Nurses Association-UK in London in August 2008. The main nurse leaders are based in London. They have organised some cultural events with food and drinks, charging a nominal fee. These include celebrating Nepali New Year in April 2009 and 2010 and *Teej* (a major Hindu women's festival) in August 2009. Their events are advertised on a Nepali Diaspora website called "Big Nepal".<sup>134</sup>

Most importantly, the main idea behind establishing this organisation was to create first a support network and then perhaps develop a nurses' trade union and welfare organisation for Nepali nurses. They had an election in May 2009 to set up a board to direct and lead the group. As of August 2010, they are still working on drafting a constitution, and towards distributing and expanding membership, charging only a small fee.

#### *Other Diaspora networks*

Similar to the nurses' network, various types of social support networks for the Nepali Diaspora are developing in the UK. The total Nepali population, not just of nurses, is rising in the UK. While Runnymede Trust's research estimated that there could be as many as 50,000 Nepalis living and working in the UK in 2008 (Sims 2008), the Centre for Nepal Studies in the UK (CNSUK) estimated this number to be as high as 80,000.<sup>135</sup> In its website CNSUK lists over fifteen such network groups in London and the south east of England; some are big and others are small. This area is where almost two-thirds of Nepalis in UK live.

Most of these networks have been set up since 2000, although Yeti Association was started in the 1960s when there were very few Nepalis in Britain, mainly from social elites, or diplomats: it remains very active in reuniting Nepalis.<sup>136</sup> There is also a new network of Nepalis in Scotland called "Nepal Scotland Association" based in

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<sup>134</sup> <http://bignepal.com/forum/index.php?/topic/8319-nepalese-nurses-association-in-uk-cultural-programme> Accessed on 4 September 2009.

<sup>135</sup> Interview with the Director of the CNSUK, Edinburgh, April 2009.

<sup>136</sup> <http://www.yetiuk.org/static.php?cate=About%20Us> Accessed on 4 September 2009.



Edinburgh with satellite groups in Aberdeen and Glasgow.<sup>137</sup> There are some smaller religious groups (such as the Buddhist Society) in London and new professional groups (such as the ex-Gurkhas Association, and Non Resident Nepalese (NRN) group). Nurses who are interested in one of the groups and who live nearby or within commutable distance have been part of these Diaspora networks. As with the Nurses Association, these network groups organise and celebrate *Teej*, *Dasai*, *Tihar* and other major Nepali festivals.

Skype and cheap mobile phones have also been vital for maintaining family and cultural ties while living in the UK. Chanda and Maheshwor, for example, had skype and webcam assisted *nawaran* and *pasni* of their son. According to Hindu religious practices, *nawaran* (naming ceremony) takes place on the 11<sup>th</sup> day after a baby's birth and *pasni* (first rice-feeding ceremony) at five to six months of age. On the 11<sup>th</sup> day after the birth of Chanda and Maheshwor's baby, they held a *nawaran* very comparable to what would have happened if he had been in Nepal. Three Brahmin *pandits* and guests were invited in their family home in Nepal and a few guests were invited to their flat in Edinburgh. For the actual ceremony, a ritual *mandap* (a temporary porch-like structure created for worshipping and performing religious rituals) was established in their family home in Kathmandu and a *pandit* conducted the rituals there. Things were planned this way because the family were aware that a *pandit* would not be available in Edinburgh to perform this ritual. At the Edinburgh end, the baby was put next to a computer and webcam. While the *pandit* was performing the *puja* (Hindu religious rites) in Nepal, he was communicating with Maheshwor and Chanda in Edinburgh. The *pandits* were reading religious verses in Sanskrit and giving instructions as to the performance of every step of the rituals accordingly. The ceremony took a couple of hours, and Chanda and Maheshwor followed it very closely. The *pandits* saw the baby on the computer screen, as needed for the ceremony. Everybody in the family had *tika* (a rice, yogurt, red vermillion mixture, applied to the forehead, as a blessing during religious or cultural ceremonies, or for good luck), and there were feasts afterward, in both Nepal and Edinburgh. Six months later, Chanda and Maheshwor held their baby's feeding ceremony in similar fashion. Again a big feast was prepared for all the guests to celebrate. I joined them

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<sup>137</sup> further information can be found at <http://nepalscotland.org/index.php> Accessed on 4 September 2009.

only for the feast after the ceremony, but Chanda and Maheshwor had it all recorded it on their camcorder.

#### **D. Future hopes**

##### *Permanent residency (PR)*

Obtaining permanent residency status and a settlement visa in Britain is a key priority and a common goal for all nurses and their families. This gives them greater freedom and mobility. Sumi's personal story, presented in Chapter Six, is very similar to those of all the nurses I have met working in the UK.

At the time of my research fieldwork, the UK Home Office - Border Control Agency regulation for foreign nationals was that, to become a permanent resident in the UK, a person had to live and work for five years as a work permit holder. After five years, s/he becomes eligible to apply for permanent residency or a settlement visa. With this visa, a nurse no longer needs to obtain a work permit when she applies for a new job in the NHS, or other areas: she can work wherever she likes. As permanent residents in the UK, nurses can obtain home student status if they wish to go to university or for any further education. They can travel in and out of the UK whenever they like, as long as they maintain some social links in the UK. For many nurses and their families, their main goal was to wait for PR. Nurses like Sumi, who had a permanent job with a work permit, were just waiting for this next. This seems to be another major achievement in their lives, which many nurses I met were determined to obtain.

I met Kripa in London in Summer 2007. She had her husband and ten year old son with her. She was working in a private nursing-home there, and waiting patiently for the time when she could become a permanent UK resident. She said:

Once we have the PR visa we can come and go in and out of Britain as and when we like. We have struggled so much and have come this far, next I just have to wait until I get PR.<sup>138</sup>

'PR' not only opens up many opportunities for Nepali nurses, but it also seems to carry a huge symbolic value in migrants' social lives. It becomes the main success indicator and nurses seemed proud to be able to share this with their friends and

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<sup>138</sup> Interviewed on 15<sup>th</sup> March 2007, Wembley London.

families. When a nurse becomes eligible for a PR visa, and when she receives this status, it becomes public knowledge quite quickly amongst the Nepali nurses' community. For example, in the spring of 2009, I was speaking on the phone with a Nepali nurse in Hastings. The first and most important piece of news she wanted to share with me was how many nurses she and I knew who had received PR. She also stressed that getting PR is a major achievement in nurses' lives which represents a new social position that they have earned. As Kripa said, they can come and go as and when they like, achieving a great deal of freedom with their mobility and deciding where they want to live and work.

### *Desire to work in the NHS*

Obtaining employment in the NHS seems the next progression for many of the nurses who are not in the system yet and for those who have not given up hope. Access to an NHS job seems just as hard as entry into Britain, for nurses from many of the countries from which nurses' recruitment is banned. Many nurses seek permanent residency status so that they can step into the NHS. They will no longer need to rely on their work permit or turn to agents for help. Nineteen out of the twenty-one nurses I interviewed said that they wished to try and wait for a permanent residency visa and then join the NHS.

### *Further studies*

All of the nurses said they would like to further their academic and specialist education. Some nurses wanted to undertake higher university degrees, whilst others wanted to become specialist nurses. Nurses are aware that university fees are very expensive for them, as they are unable to qualify for home students' status for a long time. Those who expressed a desire to become specialist nurses knew that training places are available only for nurses who are working in the specialist areas, usually within the NHS. It is again another dream for them.

### *Onward migration to the US or to Australia*

I met some unmarried nurses frustrated with the working conditions in the UK who told me that they might look for other opportunities elsewhere in the West. There are

many who have found the hurdle of NMC registration and getting a permanent nursing job difficult, and have decided that they might consider another country. One nurse moved to Australia in summer 2009 and others were looking for opportunities in the USA. I also found evidence of this when I reviewed records in nursing colleges in Nepal: letters of correspondence with nursing authorities in various countries, including some letters which showed that some nurses were trying to move to the US, some to Australia, while they were still based in the UK. Some nurses were preparing to sit the American Nursing Licensing exam from the UK. Not only Nepali nurses try to look for better opportunities in other developed countries: this is a widely-known phenomenon for many overseas nurses (Buchan *et al.* 2004).

## **Conclusion**

Nurse migration has created unsettling experiences not only for nurses, but also for their immediate families: their dependent children and husbands. Nurses and their families have faced many challenges with social adjustment in Britain and regularly feel extreme frustration. They are not yet ready to go back to Nepal, however, because it would be *laglagne* or *be-ijjet* (shameful or embarrassing) for them. They would run the risk of losing face and of people in Nepal doubting their social position in Britain. As a consequence, achieving something tangible and visible is very important for all of them before they consider returning to Nepal, even for a family visit. I also sense that the majority of nurses are trying to make a permanent move to Britain, so that when they find a full-time job and work permit, they can start bringing their families over, buy a house, and invite their extended relatives to visit. Perhaps it is too soon to speculate about their long-term motives just yet, but as of August 2010, there is no sign of nurses returning to Nepal in the near future.

This chapter has presented a mixed picture of nurses' social lives in Britain. On the one hand nurses seem to have very restricted social lives and there are many challenges that nurses and their family face with setting in the UK. At the same time, there seem to be growing Nepali Diaspora networks, even though not all nurses have been able to utilise these networks fully because of time constraints, their geographical location and other circumstances. Wherever they were and whatever visa they had, most of the nurses were waiting for PR and then planning work in the NHS. They all felt that PR would open up their future opportunities. If they failed,

they would even consider moving to another country such as the US or Australia, but there would be no going home to Nepal without some successes, whether gaining higher education, or PR, or material achievements.

Moving from here, the next chapter discusses the main findings of this research; the impact of nurse migration in Nepal, and nurses' professional situation in the UK. It finishes with some policy recommendations.

## CHAPTER EIGHT

### **CONCLUDING DISCUSSION: NURSE EDUCATION IN NEPAL AND NURSES' MIGRATION TO THE UK**

To close this thesis, I revisit my original research questions: *why* do Nepali nurses migrate to the UK and *how* do they experience the whole process? As the thesis has shown, some key interlinking factors and forces have been crucial in determining Nepali nurses' migration to the UK. Globalisation in technology; easy and quick travel facilities and Diaspora networks in the UK; immigration policies, professional regulations regarding overseas nurse registration and employment of overseas healthcare professionals, all affect why nurses migrate and how they experience the processes. The NMC UK registration process and the UK immigration and work permit policies have acted as barriers or control mechanisms for the migration of Nepali nurses, but the availability of care work in private nursing-homes, NVQ and health related courses in further education colleges in the UK have attracted Nepali nurses. I reiterate my focus on the nursing workforce situation in Nepal, highlighting the impact of nurse migration within the profession, on nurse education and the service, and then on Nepali nurses' experience of work and their social lives in Britain.

#### **The impact of nurse migration on nurse education and healthcare provision in Nepal**

It has been increasingly noted that international nurse migration has major impacts on nurse education in source countries, but this has been one of the least explored aspects of nurse migration globally (Kingma 2006; Matsuno 2008; Hancock 2008; Buchan 2008). This thesis has attempted to bridge the gap by exploring the impact of this on nurse education in Nepal.

As Chapter Three showed, there have been some significant professional transformations in nurse education in Nepal, mainly since the 1990s. Firstly, there has been a rapid expansion in training capacity, but without any preparation for increasing and strengthening training resources. This expansion increases the overall surplus of nurses so that more nurses are available for international supply. The production of

this surplus has resulted in training resources being completely overstretched. This is compounded because many senior and very experienced nurses - Nepal's key nurse training resources - are migrating to the UK, USA, Australia and New Zealand. Thus Nepal's nurse education system has lost many highly qualified and experienced academicians and practitioners, and there has been very little effort made by nurse education institutions to prepare their own academic faculty and improve the situation.<sup>139</sup>

In addition, the training curriculum in Nepal has been recently modified to match the nursing care needs of western countries. These changes have been justified as bringing Nepali nursing training up to "international training standards". New colleges and programmes have been developed to meet this need. New BSc. nursing courses began in Nepal in the 2004-05 academic session, for example, but with no posts in Nepal created for BSc nursing graduates. These recent developments ignore Nepal's domestic healthcare requirements.

As the World Health Organisation and other concerned authorities have emphasised, international nurse migration from developing countries, such as Nepal, has had adverse effects on nursing service provision in the source countries. In Nepal, government-run hospitals, particularly those outside the Kathmandu valley, have been chronically understaffed and this neglect has been getting worse year-by-year (NSI 2006; Justice 1984). As I discussed in Chapter Three, the recruitment and deployment of nurses in most hospitals has been a major challenge for the MoHP Nepal. Nursing staff turnover in most institutions is exceptionally rapid. Tribhuvan University Teaching Hospital (TUTH) is one such example of this. One of the major state-funded teaching hospitals, and formerly viewed as one of the most desirable work places in Nepal, it is now also affected by international nurse migration. In summer 2005, four ICU specialist nurses left TUTH in just one week. Clearly, it takes many years for TUTH to prepare nurses to work in these highly specialised units. In many instances, TUTH has to send nurses to Japan and India for specialist training. Losing highly-trained and experienced staff to overseas migration is a huge loss for Nepal's healthcare system.

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<sup>139</sup>Detailed discussion on this is available in my paper entitled "Nursing Business Complex: understanding nursing training in Nepal", which was published in *Studies in Nepali History and Society* 13 (2): December 2008; please see appendix.

But it is not only senior and experienced nurses who leave. Young and newly-qualified nurses are not interested in establishing a career in Nepal. As a result of the migration of young and talented and senior and experienced nurses' some feel; "now in Nepal there are only elderly ladies left behind doing nursing" (Subedi 2006). The crucial question of what will happen when these "elderly ladies" retire remains unanswered. This has a direct impact on nursing service provision, future nursing workforce planning, and ultimately on patients' safety and the quality of nursing care.

#### *Lack of leadership at national policy level*

This thesis has also explored how this situation is exacerbated by a lack of nurse leadership in the MoHP, where the country's nursing policy decisions are made. There are only a few policy level positions for nurses and these all became vacant while I was conducting this research. The Chief Nursing Officer's post has been vacant for almost two years, and had still not been filled by January 2010.

There is generally a lack of interest in long-term government jobs. Student nurses indicate that they would prefer to work abroad. Experienced nurses have already left, as we have seen. Not only is the training in Nepal directed towards meeting an "international standard", but there is no effort by the government, or any other authorities, to retain the younger generation of nurses. As highlighted in Chapter Three, poor nursing workforce planning, weak coordination and joint planning between nurse training and employing authorities are major concerns for the healthcare service in Nepal and need immediate attention.

#### *Commoditisation of nurse education: increased private sector involvement*

The political economy of nurse training was one focus in Chapter Three. Every year there is an increased number of applicants for nurse training, feeding the market conditions for increasing private sector involvement. Nursing, as with much other technical and professional education, is now seen as a commercial opportunity. Training is available for those who can afford to pay. It is notable that many middle-class parents start channelling their daughters to private schools, in order to gain a place in nursing. Many young nurses are therefore from well-off sections of society. While there are young women from poorer socio-economic backgrounds who would



consider nursing as a career, many ordinary Nepali women (whose parents are not able to pay for the training costs) stand no chance of being accepted for the training. There are only a very few scholarships available for exceptionally talented students, but ironically, these talented individuals usually have greater ambitions, to migrate once they are qualified.

However, there are some positive shifts too. Migration opportunities for nurses have raised the profile of the profession. Increasingly, for some families nurses and daughters have been seen as major social assets, reflecting a major change in Nepali society.

### **Nurse migration, contemporary social change and changes in gender dynamics in Nepal**

The discussion in the Chapters Two and Three provided an overview of nursing and its relation to changes in women's social position. The establishment of nursing as a profession reflects changes in women's position in Nepali society. In recent years, an increasing number of women are engaging in paid and professional positions. Those who take up nursing as a profession are considerably sought-after socially, as the most desirable marriage partners for young educated Nepali men. Nurses are seen as being more independent, mobile and enjoying more freedom. The traditional arranged marriage system is gradually changing, and now nurses can have a say when it comes to making marriage decisions.

#### *Nursing and changing marriage patterns*

Only one generation ago “*chhori bigryo nurse-le, chhora bigro commerce-le*” (“daughters get corrupted by being a nurse and sons by studying commerce”) was a common saying in Nepal. Nursing was then a relatively new profession and was still to gain social recognition and respect. Although nurses at that time were from relatively educated, and mostly high caste, families the saying was commonly heard across many classes and in many social groups. Nursing was not the most desirable job for women. As explained in detail, it was not socially acceptable for a young woman to move away from home, as this could potentially ruin family *ijjet*, or honour.

However, by the beginning of the 21<sup>st</sup> century, this attitude had completely changed. Now qualified nurses are much in demand for marriage, because their qualification is not only seen as guaranteeing a job in Nepal, but also seen as a job licence to work abroad in more developed countries. Nurses have considerably more bargaining power and gender relations are shifting. This issue has been much discussed by the media, and quite regularly too, mainly since international nurse migration began in Nepal.

*Migration to the UK (and elsewhere abroad) is symbolic capital in Nepal*

An opportunity to migrate to the UK, USA, Australia and Canada has a great symbolic value in contemporary Nepali society, yet only a small number of privileged groups of people can make this dream come true. One needs enough money, the right kind of education, and the right social networks and connections to facilitate migration. Obtaining a visa to enter the UK or any developed country in itself is already seen as a mark of success in people's lives (as discussed in Chapter Four). To have social and family networks abroad, especially in major developed countries like the UK, the USA, Canada, Australia, New Zealand, and Japan is viewed as a big asset for people who are left behind in Nepal. Seeing a family member making the journey raises others' hopes of migrating or starting chain migration. People who have family members, friends or relatives abroad are proud of this link, and this is particularly evident within middle-class social circles in Nepal. The link abroad and the receiving of foreign goods raise people's social status.

*Nurse migration: opportunities and costs for the whole family*

By migrating to the UK, many nurses have enhanced the educational opportunities for their children's and even husbands' further education. Most professionals in Nepal could never afford to send their children to the UK for schooling. Nurses' children are now studying in universities in the UK; some are studying medicine and engineering. These professions are considered at the top of a career hierarchy in Nepal. For these nurses' families, these opportunities would have been impossible if they had not left Nepal. This is another (indeed the best) measure of success for nurses and their families.

At the same time, however, the improved opportunities for women have made some men feel compromised in their social positions. Men, who have migrated to the UK as dependant husbands, feel demoralised and frustrated because they do not have the same social position they would enjoy in Nepal, and they have little bargaining power in the UK job market. This was explored in Chapter Seven. Nurse migration has a profound effect on traditional male roles. For the Nepali Diaspora in the UK, not all men are the head of a family and the bread-winners. Nurses' husbands who have come to the UK as dependant family members do not seem to enjoy being dependant.

Finally, and most importantly, international nurse migration has created highly inflated expectations. Student nurses, newly qualified nurses and their families see nursing as route to foreign jobs, as a sign of success and modernity that offers better futures for individuals and families. In following nurses' migration journeys to the UK it is clear that, for some migrant Nepali nurses, their journey to the UK has been a mixed blessing: both painful and successful. Because tighter border controls and professional regulations act as major barriers for nurses, not all aspirants can overcome all the practical hurdles. These issues are not clearly foreseen by nurses and their families, leading to frustration and feelings of failure. Unfortunately for those who are still working in Nepal, unable to obtain visas or without the means even to try to go abroad, they experience this as failure too.

### **Nepali migrant nurses' and families' status and experience in the UK**

#### *Un-free workforce*

Migrants of various types are invited to fill vacancies for jobs commonly known as the 3 Ds: dirty, dangerous and degrading (Castle 2000). These jobs are the hard-to-fill vacancies, usually the undesired or the least desired, by the local workforce.

Migration scholars argue that this reinforces a further division within social and professional classes. This has been evident within the nursing profession in the UK. Smith & Mackintosh (2007) argue that the present pattern of international nurse migration and the increasing commercialisation in the healthcare service in the UK has created a professional class, where a white British workforce occupies the managerial level and the most desired positions, and migrant nurses increasingly provide front-line hands-on care. Despite having high qualifications and many years

of work experience in various specialist and management positions, Nepali nurses in the UK are in the exact position described by Smith and Mackintosh. Their experience and qualifications in Nepal are usually not recognised. Many are left with very little career choice but become tied to a work permit for private nursing-homes. Compared to the facilities and privileges their British and European counterparts enjoy, Nepali nurses are certainly second-class nurses in Britain.

Many migrants are controlled and tied to their jobs. Castle (2000: 95-96) pertinently describes migrants as “*un-free labour*”. In the same way, overseas nurses are “*un-free professionals*”. When nurses migrate to the UK to work, their professional scope is determined by their work permit, and work permits are attached to certain jobs in certain nursing-homes. They cannot change their jobs or move anywhere easily, even if they feel discriminated against and exploited at work. I have illustrated this with empirical evidence, throughout Chapters Five, Six and Seven. The argument goes back to my introduction, and Mary’s story symbolises this point. Eventually, vulnerable nurses like Mary accept their circumstances, and discrimination and exploitative practices become the social norm (Larsen 2007). Overseas nurses’ professional scope becomes contracted and they rapidly become deskilled.

### *Deskilling*

Migrant workers are not only involved in ‘dirty, dangerous and degrading’ jobs (Shelley 2007; Castle 2000) but Nepali nurses are increasingly becoming deskilled. Professional migrants becoming deskilled is a widely known and discussed issue. Many of my informants in the UK were highly experienced in CCU/ ICU nursing, in theatre nursing, and in maternity services in Nepal. Many are losing their invaluable professional skills even though, paradoxically, some of these skills are highly sought-after by the NHS in the UK.

This is described by some Nepali nurses as a “*trap*” in their dreams and aspirations. After being in the UK for some time and working in the care of elderly and long-term care settings, their valuable skills in management, teaching and in the highly technical fields like ICU and CCU are disappearing. Now nurses feel that they cannot even go back to their old jobs in Nepal, and they find very little opportunity for career

progression in the UK. This finding supports the well recognised phenomenon of deskilling amongst other overseas nurses (Allan & Larsen 2003).

### **Management of nurse migration: some policy recommendations**

These findings lead me to make some policy recommendations for all key stakeholders concerned with nurse education in Nepal and the subsequent international migration. International nurse migration is a complex issue and this trend is on the rise globally, so better and strategic management is today's need. The UK opened its door for overseas nurses in the late 1990s, to address an acute nursing shortage in the UK swiftly, and deal with the political need to reduce waiting lists in the NHS. While a number of NHS trusts made efforts to recruit overseas nurses, this practice was later perceived as “poaching” or “haemorrhaging” of the nursing workforces from developing countries. After being criticised as an unethical recruiter, the DH in England developed and introduced a “Code of Practice for the International Recruitment of the Healthcare Professionals” in 1999, which was further strengthened and finalised in 2004. The idea behind this guideline was to stop or discourage nurses coming to the UK from developing countries (including Nepal), and to support and strengthen these countries' vulnerable health services. As we have seen, in Chapter Five, it did not reduce the number of Nepali nurses migrating to the UK.

A crucial point is that, if the UK is genuinely interested in strengthening Nepal's healthcare services, it needs to focus on and assist with the country's specific human resources needs. There are several possible ways this could be achieved. The UK could be assisting the Nepali government in making nursing an attractive profession by finding and implementing nurse retention strategies there, rather than by including Nepal on the banned lists for nurse recruitment in the UK. Country-specific support and intervention is the pressing issue, not negative banned lists. Allocating some of the money spent on development interventions by Department For International Development (DFID) to supporting educational and career progression opportunities and improving health workers' and other benefits and rewards in Nepal would be one step in the right direction.

*The NMC and the RCN/ Royal College of Midwife should take a proactive role to support migrant nurses in job matching*

Nepali nurses are already in the UK and now is the time to use their valuable skills and experience in ways that would be beneficial both to the nurses and to the British healthcare system. To make better use of these resources, it would help the situation if the NMC were to take a much more proactive role and adopt a fair and flexible approach toward overseas nurses' registration to practice in the UK (Allan 2008). There needs to be greater professional control of the situation by the NMC. The UK border control agency and private sector healthcare employers should not be the major player in dealing with such sensitive and important issues.

As already noted, Nepali nurses have migrated to the UK after many years of experience in maternity services, ICU/CCU and specialist post-graduate training in Nepal. Experienced Nepali nurses in the UK are wasting their talents in nursing-homes. There was a shortage of about 5000 midwives in Britain in 2009. The NMC and Royal College of Midwives could jointly plan a learning support programme and help experienced Nepali nurses and midwives to move into their areas of expertise. This would benefit not just the migrant nurses and midwives but the whole UK healthcare service.

The RCN is the nurses' professional trade union body in the UK. RCN has been actively lobbying to support and improve nurses' working lives, working terms and conditions. The RCN has developed guidelines for healthcare employers in Britain with a focus on how to support overseas nurses better at work. The RCN, however, has not been able to deal with subtle discrimination towards and harassment of overseas nurses at work; this has been clearly illustrated by Sumi's story in Chapter six. The RCN needs to find ways to reach a wider group of overseas nurses and deal with their professional needs in the UK. As well as this, the RCN should develop strategies and work jointly with the overseas nurses' groups and the NMC in planning and implementing learning support programmes specifically focusing on overseas nurses' professional needs.

Other reasons that Nepali nurses have ended up in jobs that do not reflect their experience and training, leading to them becoming deskilled, also need to be

acknowledged. Firstly, the complexity of the NMC UK registration process; secondly, the Department of Health in England, whose “Code of Practice for the International Recruitment of the Healthcare Professionals” listed Nepal in the banned list for active recruitment; and thirdly, the consequent UK home office policies and work permit regulations which have placed nurses from the outside the EU as “un-free labour” health workers (Castle 2000). Many overseas nurses are tied to a job, as their work permit and the NHS have closed the door for them, and nurses have very limited freedom to look for better posts.

The NMC has a discriminatory registration policy, for example the need for nurses outside the EU to obtain IELTS with band 7 Score. The requirement that all nurses should be able to communicate effectively with patients and with colleagues at work is reasonable, if standard nursing care is to be provided. But nurses from EU countries such as Spain, Poland, and Germany do not need to demonstrate their language competency because of EU regulations on trade and freedom of movement within the EU. This fuels the further exploitation of nurses from outside EU countries, who become doubly vulnerable. The NMC would do well to have a non-discriminatory policy, with the requirement that all nurses should be able to communicate effectively.

#### *Border control policies in the UK*

Although the border control issue was not central to this research when I started the fieldwork, it quickly became apparent that it is an important issue for migrant nurses. It has a direct effect on nurses’ work permit conditions and their working lives, which subsequently determine, to some degree, nurses’ work, social lives, and social integration.

Some people in receiving societies, such as the UK, label migrants as economic migrants, who migrate to the UK to siphon off its national resources. Although there is no evidence to support this argument, this has been the attitude of many developed countries’ governments today (Moses 2006; Castle 2000). Stemming from this idea, most recipient nation states are creating increasingly restrictive admission policies. But this seems to ignore nations’ increasing interdependence and the vital role of migration in keeping national economies active. Making border regulations tighter

than ever before encourages irregular migration, which keeps wages down. But as Massey (2006: 13) states:

As countries of destination adjust their policies in response to changing conditions, migrants adjust their strategies and tailor their schemes to fit the prevailing rules in regulations.

This has been the case with Nepali nurses as illustrated in Chapter Four, Five and Six. The UK changed its border control policy in response to the Department of Health in England's "Code of Practice for the International Recruitment of Healthcare Professionals" (2004) and Nepal being placed on the banned list of countries from which nurses are not to be recruited for the NHS. Since then, Nepali nurses stopped getting work permits to work in the UK. This did not mean, however, that Nepali nurses stopped migrating to the UK, as the NMC register shows. They continued to migrate, but with different entry visas. Many nurses have migrated instead as NVQ students or as dependent family members while their husbands are on student visas. Nurses have found alternative routes to comply with the new regulations. In short, the new visa and work permit regulation has not had its intended effect. In addition, Nepali nurses have been diversifying their destination countries, with more migrating to Australia rather than the UK. The main intention of the "Code of Practice for the International Recruitment of Healthcare Professionals" was to help retain health workers in developing countries. Clearly, however, it has had no effect on health workers' migration from Nepal.

#### *No going back, so no brain circulation*

There has been considerable discussion in the literature around whether migrant skilled professionals, who return home with their newly-acquired skills, benefit their society. This possibility has been termed "brain circulation" (Kingma 2006). At the same time, there has been some concern about whether these professional skills are at all appropriate in their home context (Maija 1978; Kingma 2006). With regard to the Nepal context, Nepali nurses would not return home with very relevant new sets of nursing skills. The majority of Nepali nurses in Britain are working in long-term care settings and these skills are not so appropriate in the present healthcare context in Nepal. In addition, because nurses feel "deskilled" in Britain, they do not retain the same amount of professional skill and confidence to perform the tasks they were used



to doing, before they migrated Britain. My findings do not support the idea of “brain circulation” in the Nepal context. Further, although it is too early to speculate whether Nepali nurses will return home and share their new knowledge and experience, so far there is no sign of any of the nurses I met and interviewed in the UK doing this. As I indicated in Chapter Six, many nurses are trying to settle permanently in the UK. Nurse migration from Nepal appears much more of a “brain drain”. Finding appropriate strategies to encourage and manage “brain circulation” nurse migration are clearly important today.

The restrictive visa regulations have resulted in some nurses fearing that if they return to Nepal, they might not be re-admitted to the UK. This fear keeps nurses and other types of migrants in the UK longer than they might otherwise have chosen. Thus these policies do the opposite of encouraging nurses to return to their own countries where their skills are needed the most. Closing borders is not a remedy to the brain-drain. Rather there need to be bilateral discussions to find dynamic and flexible management solutions. Migration scholars have widely argued that international migration of skilled professionals (including nurses) is not going to be stopped by imposing border control regulations (Moses 2006; Kingma 2006; Castle 2000). In addition to flexible border regulations, modern day migration management could also include flexible professional exchange programmes. Many Nepali nurses have expressed the view that they are waiting for more freedom of mobility in their lives: freedom to choose jobs, go to college and even return to Nepal.

#### *Encourage and support circular migration for “brain circulation”*

Return migration is when migrants return home ‘for good’ and circular migration refers to their coming and going whenever desired. For circular migration, migrants need to have flexible options (Haour-Knipe & Davies 2008). I argue that migrants will return home if they have the opportunity to move about more freely and the option to return to their desired destination countries. This has been evident within the EU where people had the freedom to move between EU member states during the current economic recession. The BBC World Service published migration data on 8<sup>th</sup> of September 2009 which suggests that European migrants - for example Poles - are returning home (BBC News 2009b). Similarly, thousands of Nepalis are working in India. Nepal and India have an open border policy. Nepali migrants go to India as

seasonal workers or some even spend many years there for education. After a certain period, some return home permanently and some return to India. This type of freedom is vital for return and circular migration.

However, as I have argued in this thesis migrants from other countries, unlike EU migrants are trapped by UK border control regulations. A more relaxed and flexible border control policy would greatly assist migrant nurses and other skilled professionals to return home. Such a situation would benefit individuals and the UK healthcare system. But when border control regulations are stringent, migration becomes more expensive. Nurses are therefore more vulnerable to exploitation by the brokers, and to consequent “back door recruitment” (Buchan *et al.* 2005) by the NHS.

This research has presented pertinent new knowledge about the complex socio-political and gender dynamics in 21<sup>st</sup> century Nepal and the regulatory policies related to overseas nurse licensing and recruitment and work permits in the UK. The thesis has also clearly shown how nursing shortages in developed countries such as the UK can have wider impact on nursing education source countries like Nepal. Overall, this thesis has cast new light on international nurse migration and its impact on migrant nurses’ professional, social and family lives. These findings, then, are important resources for nursing and health workforce planners, migration policy makers, scholars of gender studies and academics who are interested in international migration.

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